

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												20490			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) #5 Edward Ave.				d. STREET ADDRESS #5 Edward Ave.											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print)		First George	Middle Francis	Last Adkins Jr.	4. DATE OF DEATH Dec. 5. 1965.	Month	Day	Year							
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18. 1924.	9. AGE (in years last birthday) 41 yrs.	10. IF UNDER 1 YEAR Months 10	11. IF UNDER 24 HRS. Days 17	12. IF UNDER 24 HRS. Hours 17	13. IF UNDER 24 HRS. Min. 17					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Production Mgr.				10b. KIND OF BUSINESS OR INDUSTRY Bakery (Bakery)				11. BIRTHPLACE (State or foreign country) Powellville, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Francis Adkins				14. MOTHER'S MAIDEN NAME Laura Adkins											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (No, or unknown) (If yes give war or dates of service)				16. SOC SECURITY NO. 214-28-8731				17. INFORMANT Mrs. Amanda M. Adkins (Wife)				Address #5 Edward Ave, Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN INSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Bullet wound of Brain											
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.				(b)											
DUE TO Underlying cause last.				(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OF CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Shot self -											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 5:15 p.m. 12-5-65				20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home				20f. (City or town) Salisbury		(County) Wicomico	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Carl L. Royer</i>		EXAMINER'S NAME (Type) Earl L. Royer		22. DATE SIGNED 12-2-65		Address (Street, City, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 5. 1965.		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Forest Grove Cemetery		23d. LOCATION (City, town or county) R.D. Parsonsburg, Md.		(State) Md.		25a. REC'D BY REGISTRAR DEC 9 1965				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
24. FUNERAL DIRECTOR Holloway & Co. Salisbury, Maryland.															

(17) - 1970 (1971) (1972)

Ward to bush-tellus

Feb 2012

to new field with 2021 Date

new - 61 productive traps, 1-23

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17109

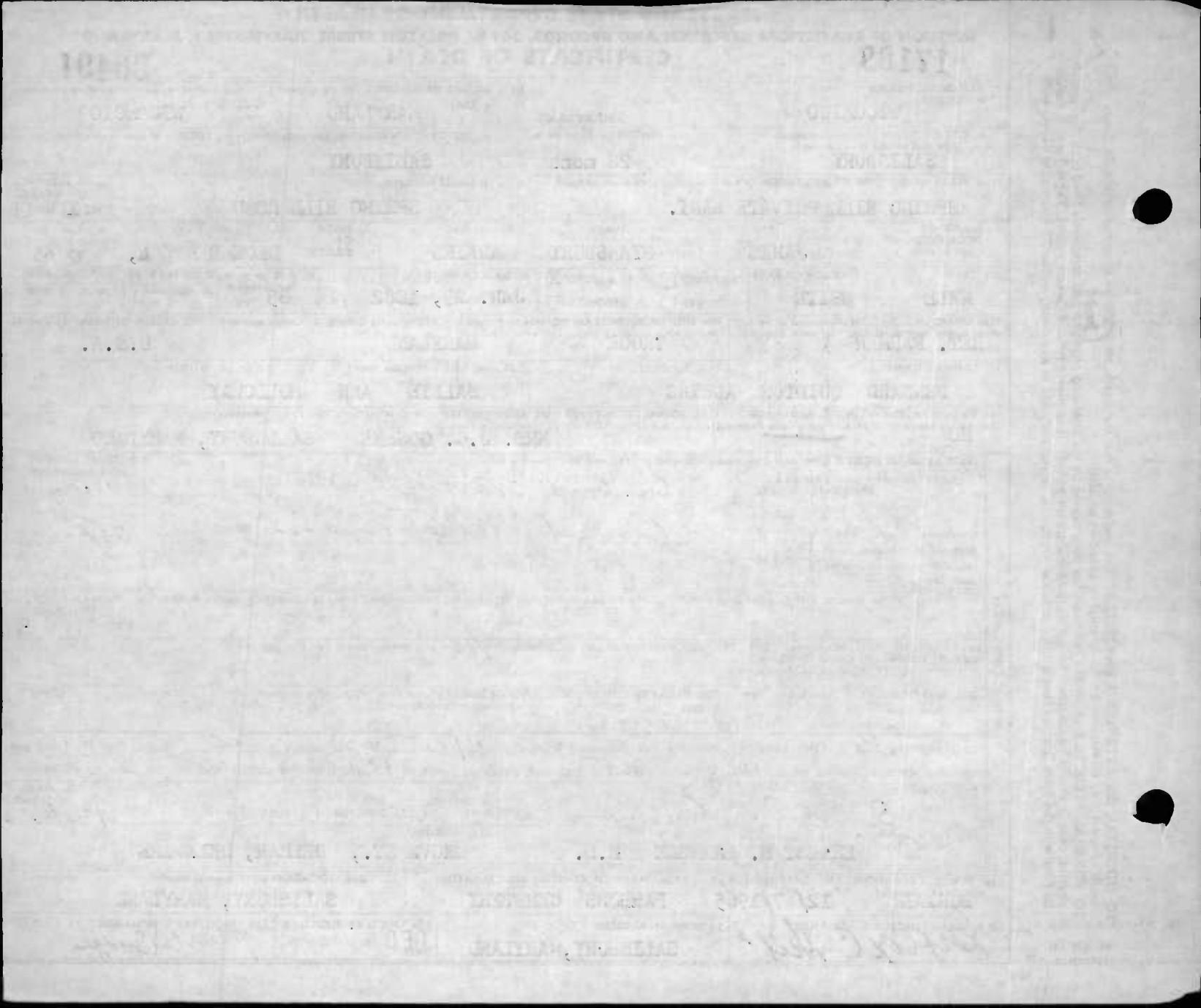
CERTIFICATE OF DEATH

20491

2
1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WICOMICO		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN lb 28 mons	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING HILL PRIVATE SANI.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X SALISBURY	
3. NAME OF DECEASED (Type or print) JAMES STANSBURY		f. STREET ADDRESS SPRING HILL ROAD	
3. NAME OF DECEASED (Type or print) JAMES STANSBURY	First JAMES	Middle STANSBURY	Last ADKINS
4. DATE OF DEATH DECEMBER 4, 1965	Month DECEMBER	Day 4	Year 1965
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JAN. 29, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. FARMER	10b. KIND OF BUSINESS OR INDUSTRY TRUCK	11. BIRTHPLACE (County & State, or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME DENNARD QUINTON ADKINS	14. MOTHER'S MAIDEN NAME SALLIE ANN HOLLOWAY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO	16. SOCIAL SECURITY NO. 	17. INFORMANT MRS. J.C. GOSLEE	Address SALISBURY, MARYLAND
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332 X			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cerebral thrombosis	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) 		(County) 	(State)
21. I certify that (I) (this hospital) attended the deceased from 6/1/65 , 1965 to death , 19....., that (I) (we) last saw the deceased alive on 12/7/1965 , and that death occurred at 1 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Ernest M. Larmore		22b. DATE SIGNED 13/6/65	
22c. PHYSICIAN'S NAME (Type) ERNEST M. LARMORE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS GROVE ST., DELMAR, DELAWARE
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/7/1965	23c. NAME OF CEMETERY OR CREMATORIAL PARSONS CEMETERY
23d. LOCATION (City, town or county) SALISBURY, MARYLAND		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE George C. Miller		ADDRESS SALISBURY, MARYLAND	25a. REC'D BY REGISTRAR DATE DEC 10 1965
			25b. REGISTRAR'S SIGNATURE Charles Judge



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
17110				20492								
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE <u>MARYLAND</u>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> - 13x.2								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 82 PENINSULA GENERAL HOSPITAL				d. STREET ADDRESS Rt. 2 Box 299								
3. NAME OF DECEASED (Type or print) <u>ALBERT</u>				First	Middle	Last	4. DATE OF DEATH Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1893</u>		9. AGE (In years last birthday) <u>72 yrs.</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Elsie Brittingham-Pocomoke, Md.</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acidosis and Dehydration</u> INTERVAL BETWEEN ONSET AND DEATH <u>1wk</u> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <u>260x</u> DUE TO <u>Renal Insufficiency</u> <u>1wk</u> (b) DUE TO <u>Diabetes Mellitus Uncontrolled</u>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Umbilical Hernia, Large Prostatis, Int. Hemorrhoids</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> p.m. at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) <u>Pocomoke</u>		(County) <u>Md.</u>	(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/11/65</u> , to <u>12/12/65</u> , 1965, that (I) (we) last saw the deceased alive on <u>12/12/65</u> and that death occurred at <u>12/12/65</u> M, from the causes and on the date stated above.												
22a. SIGNATURE <u>Reverend Gardner</u> 22b. DATE SIGNED <u>12/13/65</u>												
22c. PHYSICIAN'S NAME (Type) <u>Russ S. GARDNER, JR.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Medical Center, Salisbury, Md.</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>12-18-65</u> 23c. NAME OF CEMETERY OR CREMATORIAL <u>St. James</u>				23d. LOCATION (City, town or county) <u>Pocomoke, Md.</u> (State)								
24. FUNERAL DIRECTOR <u>Edgar Wharton</u>				ADDRESS <u>New Church, Md.</u> 25a. REC'D BY REGISTRAR <u>DEC 17 1965</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

EC105

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most people go to

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MARYLAND STATE DEPARTMENT OF HEALTH

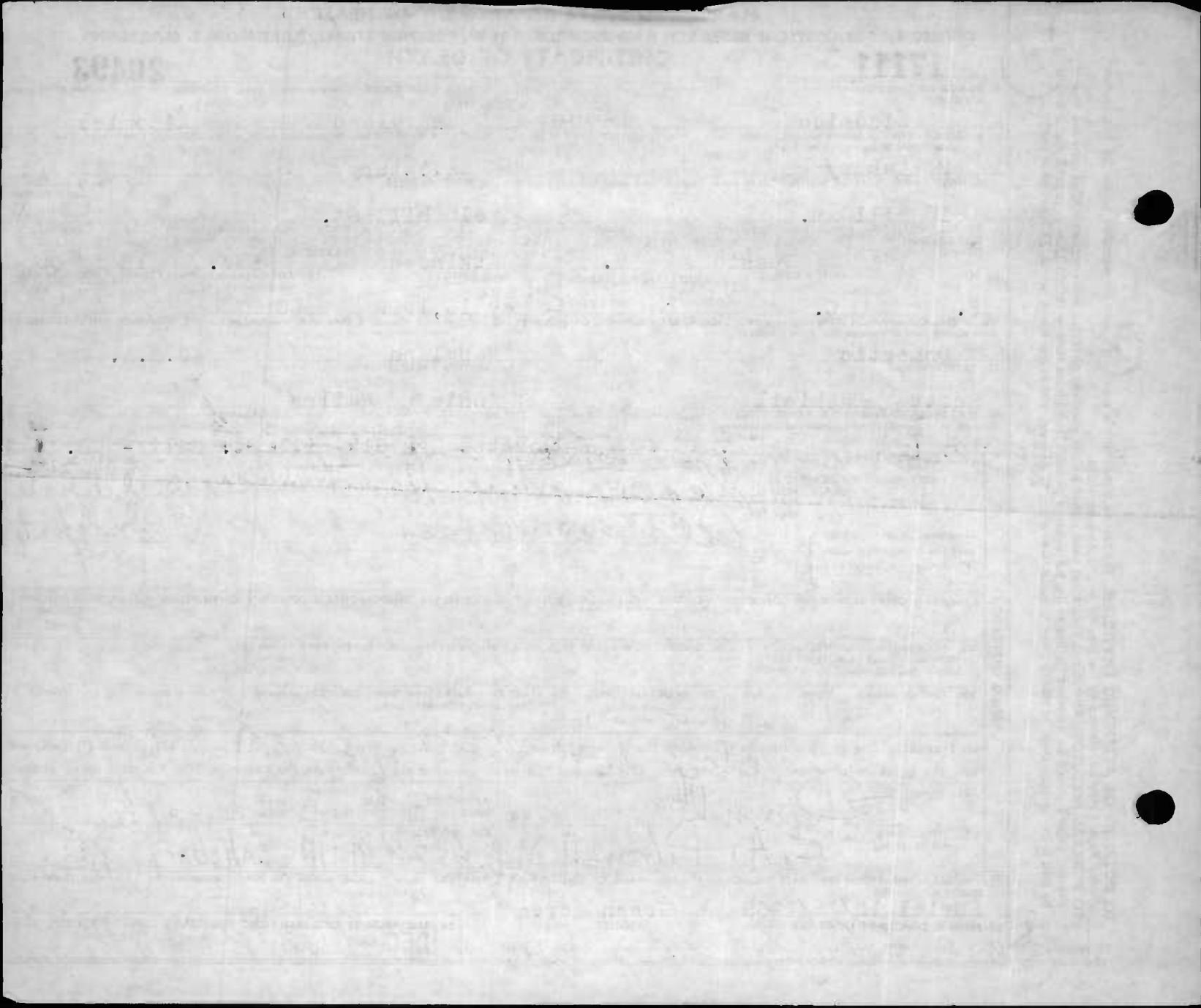
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17111

CERTIFICATE OF DEATH

20493

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)	
Wicomico		e. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Wicomico	
Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		12 Salisbury	
615 Hill St.		d. STREET ADDRESS	
First Middle		Last Month Day Year	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
Gussie M. Atkinson		Dec. 18 1965	
5. SEX		5. COLOR OR RACE	
F. C.		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
		7. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10d. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH	
Domestic		May 16, 1909	
10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	
		56 yrs. Months Dey Hours Min.	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Scott Dashiell		Annie Wailes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT	
		Doretta Orr 615 Hill St. Salis- Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Definite	
4221 DUE TO		Indefinite	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) } DUE TO		Indefinite	
{		Arteriosclerosis	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/22/65 to 18 Dec 1965, that (I) (we) last saw the deceased alive on 18 Dec 1965, and that death occurred at 10 A.M. from the causes and on the date stated above.		22b. DATE SIGNED	
22e. SIGNATURE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
F. A. Turnell M.D. 652 W MAIN SALISBURY, MD.		26 Dec 65	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial 12/22/1965		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
Green Acres		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Clinton E. Stewart Salis - Md.		Salisbury DEC 27 1965 Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)											
a. COUNTY <i>Wicomico</i>				a. STATE <i>MARYLAND</i>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>				c. LENGTH OF STAY IN 1b <i>12336 Catherine St</i>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Peninsula General Hospital</i>				d. STREET ADDRESS <i>Salisbury Md</i>											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year						
<i>Dulaney Norman Ayers</i>						<i>December</i>	<i>9</i>	<i>1965</i>							
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR					
MALE		Colored		NEVER MARRIED <input checked="" type="checkbox"/>		10-2-1900		65 yrs.		IF UNDER 24 HRS.					
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>						Months	Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
								<i>Accomac Va.</i>				<i>U.S.A.</i>			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME												
<i>Jerry Ayers</i>			<i>Maggie Jacobs</i>												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address						
(If yes give war or dates of service)			<i>214-10 9444</i>			<i>Cora Ayers</i>			<i>336 Catherine St. Salisbury</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Regenerative Heart Disease</i>															
4221 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Atherosclerosis</i>															
DUE TO (c) <i>Indefinite</i>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Indefinite</i>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)						
<i>19</i>															
21. I certify that (I) (this hospital) attended the deceased from <i>1 Nov 1965</i> to <i>9 Dec 1965</i> , that (I) (we) last saw the deceased alive on <i>9 Dec 1965</i> , and that death occurred at <i>4 PM</i> , from the causes and on the date stated above.															
22a. SIGNATURE <i>E. A. Pyrnell</i>															
22b. DATE SIGNED <i>13 Dec 65</i>															
22c. PHYSICIAN'S NAME (Type)			M.D. ATTENDING PHYS.			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS <i>652 W Main Salisbury Md</i>						
23a. BURIAL, CREMATION, REMDVAL- (Specify) <i>Burial</i>			23b. DATE THEREOF <i>12-13-65</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Green Acres</i>			23d. LOCATION (City, town or county) (State) <i>Salisbury, Md</i>						
24. FUNERAL DIRECTOR <i>Loretta B. Jolley Jersey Rd Salis. Md</i>			ADDRESS			25a. REC'D BY REGISTRAR <i>DEC 20 1965</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

REVIEW



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

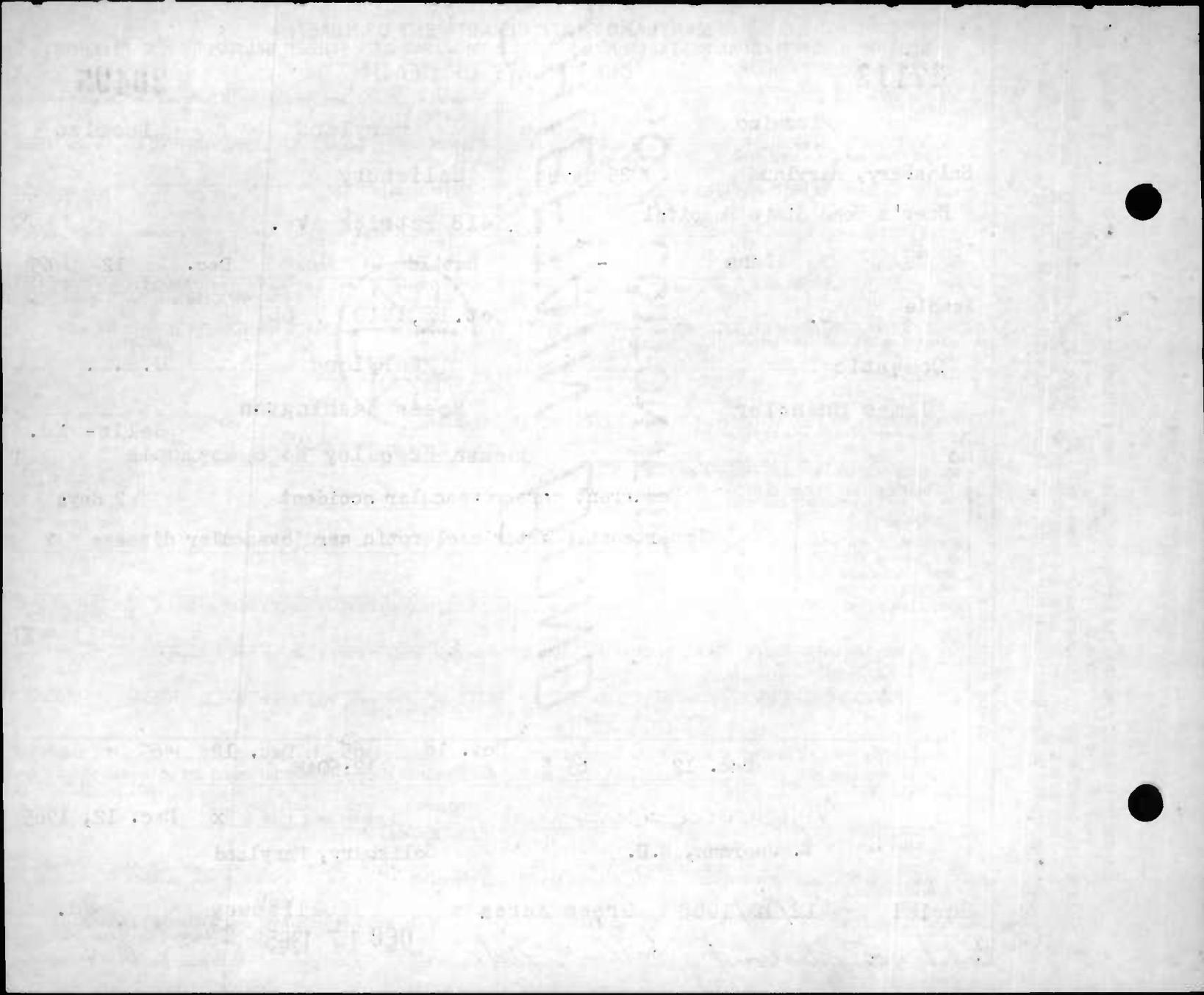
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

21495

17113		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)									
a. COUNTY Wicomico		b. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN 1b 25 days									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital											
3. NAME OF DECEASED (Type or print) Female Lena		First	Middle	Last	4. DATE OF DEATH Battle	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX Female		6. COLOR OR RACE C.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1910	9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME James Chandler		14. MOTHER'S MAIDEN NAME Roase Washington		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Odessa MCNealey No 6 Nokmonis		Address Salis- Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent cerebrovascular accident 443X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic cardiovascular disease ? (c) DUE TO DUE TO DUE TO										INTERVAL BETWEEN DNSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Salisbury		(County) Md.	(State) Md.		
21. I certify that (I) (this hospital) attended the deceased from Nov. 18, 1965, to Dec. 12, 1965, that (I) (we) last saw the deceased alive on Dec. 12, 1965, and that death occurred at 12:50 AM, from the causes and on the date stated above.											
22a. SIGNATURE V. Juerman		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Dec. 12, 1965			
22c. PHYSICIAN'S NAME (Type) V. Juerman, M.D.		22d. ADDRESS Salisbury, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/14/1965		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Green Acres		23d. LOCATION (City, town or county) Salisbury		(State) Md.			
24. FUNERAL DIRECTOR Charles E. Stewart						25a. REC'D BY REGISTRAR DEC 17 1965		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester																
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 8½ hours			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salem			d. STREET ADDRESS													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
3. NAME OF DECEASED (Type or print)		First John	Middle Wesley	Last Boardley	4. DATE OF DEATH Month Dec. Day 6 Year 1965	Month Dec.	Day 6	Year 1965	5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1882	9. AGE (In years at birthday) 83 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. Father's Name unk.	14. Mother's Maiden Name unk	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 7	17. INFORMANT Norman Chase	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease, decompensated												INTERVAL BETWEEN ONSET AND DEATH Years										
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. 4221			DUE TO (b) _____ DUE TO (c) _____																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Dec. 6, 1965 , to Dec. 6, 1965 , that (I) (we) last saw the deceased alive on Dec. 6, 1965 , and that death occurred at M , from the causes and on the date stated above.												22b. DATE SIGNED 7:05 P.M.										
22a. SIGNATURE V. Juerman												M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 12/7/65							
22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D.			22d. ADDRESS Deer's Head Hospital; Salisbury, Md.			23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12-4-65			23c. NAME OF CEMETERY OR CREMATORIAL Salem Cemetery			23d. LOCATION (City, town or county) Salem Dorchester							
24. FUNERAL DIRECTOR Brooks M. West			ADDRESS			25a. REC'D BY REGISTRAR DATE DEC 9 1965			25b. REGISTRAR'S SIGNATURE J. Charles Judge													

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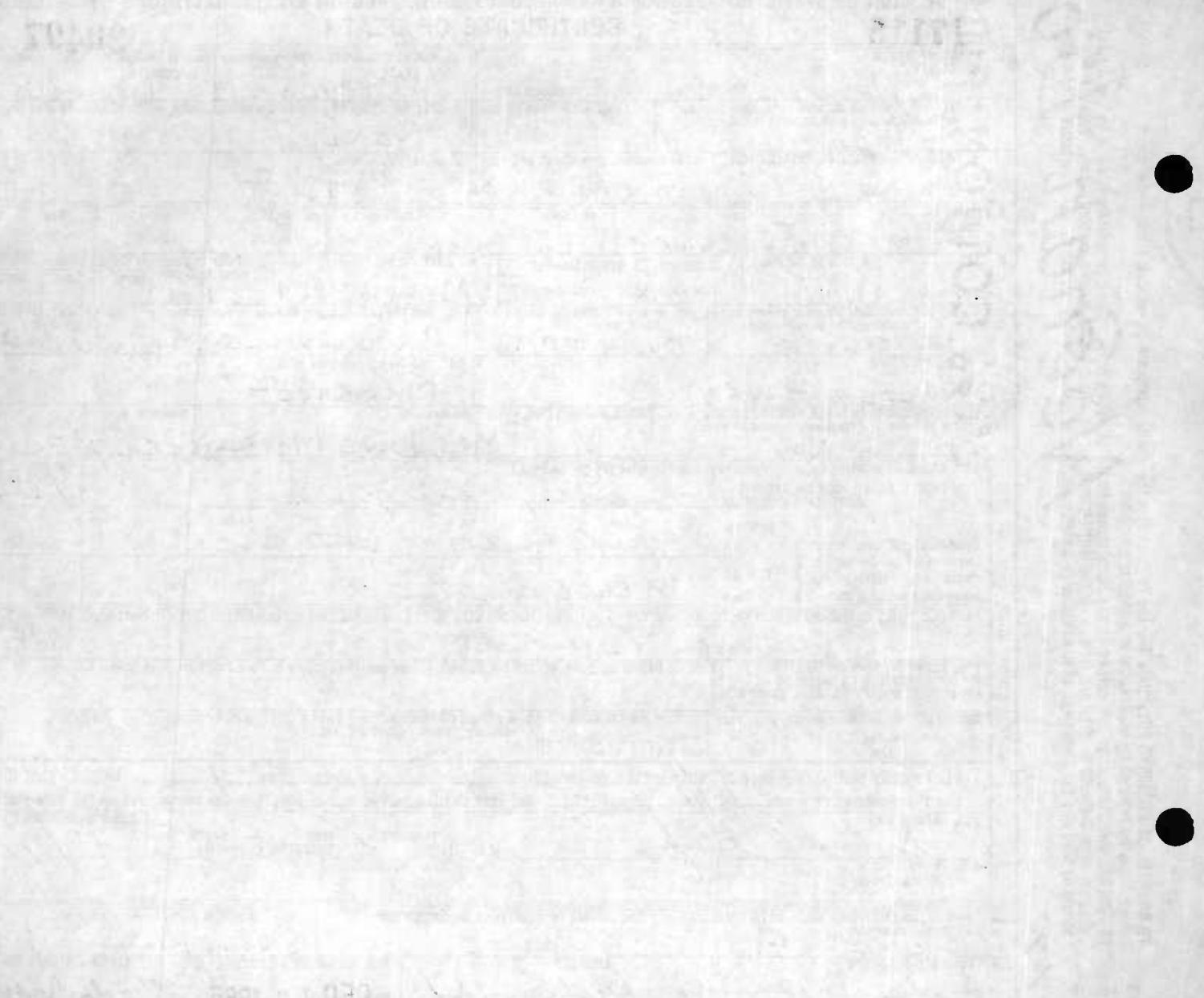
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17115

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>WORCSTER</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BERLIN</i>		d. STREET ADDRESS <i>PITTS ST 23X-2</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Peninsula General Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <i>FLORENCE</i>	Middle <i>L.</i>	Last <i>Bowen</i>	4. DATE OF DEATH <i>December 7 1965</i>	Month Day Year	Month Days Hours Min.		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 6, 1884</i>	9. AGE (In years last birthday) <i>81 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS DR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>POTOMACVILLE MD</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>WALTER ARVEY</i>			14. MOTHER'S MAIDEN NAME <i>MARGARET</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Mrs. JUNE McALLISTER, BERLIN MD</i>	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory insufficiency</i>		DUE TO <i>Trapeobronchitis & atelectasis</i>		DUE TO <i>Stained secretions</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>		
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>501X</i>		(b)		(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Cerebrovascular accident</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>No</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>While at work</i>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While Not While at work <i>at work</i>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>At home</i>		20f. (City or town) (County) (State) <i>(None)</i>		21. I certify that (I) (this hospital) attended the deceased from <i>11/4 1965</i> , to <i>12/7 1965</i> , that (I) (we) last saw the deceased alive on <i>12/7 1965</i> , and that death occurred at <i>home</i> , from the causes and on the date stated above.		22b. DATE SIGNED <i>12/8/65</i>		
22a. SIGNATURE <i>Richard E Hughes</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) <i>Richard E Hughes</i>		22d. ADDRESS <i>(None)</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/9/65</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>BATES</i>		23d. LOCATION (City, town or county) (State) <i>Snow Hill MD</i>		
24. FUNERAL DIRECTOR <i>Anna A. Burge Berlin MD</i>		ADDRESS <i>(None)</i>		25a. REC'D BY REGISTRAR <i>REC'D 13 1965</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

21198

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D.2. Pittsville, Md.		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pittsville,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At Home, Rd. 2 Pittsville, Md.		d. STREET ADDRESS / Rd. 2 Pittsville, Md.	
3. NAME OF DECEASED (Type or print)	First Lester	Middle X	Last Bradford
4. DATE OF DEATH	Month Dec.	Day 6.	Year 19 65
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WOOED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Jan. 28. 1906
9. AGE (In years last birthday) 59 yrs.	10. UNOER 1 YEAR IF UNDER 24 HRS. Months 10 Days 8 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	10b. KIND OF BUSINESS OR INDUSTRY Builder	11. BIRTHPLACE (County & State, or foreign country) Seaford, Delaware. U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Levi Bradford	14. MOTHER'S MAIDEN NAME No Record		
15. WAS DECEASED EVER IN U.S. ARMEED FORCES? (Yes, No, or unknown) Yes	16. SOCIAL SECURITY NO. War. 2 220 09 1382	17. INFORMANT Mrs. Bessie Bradford (Wife)	Address R.D. # 2. Pittsville, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH full	
DUE TO — — —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Salisbury (County) Maryland (State)
21. I certify that (I) (this hospital) attended the deceased from 10/15/65 , to 12/4/1965 , that (I) (we) last saw the deceased alive on 12/4/1965 , and that death occurred at 1A M, from the causes and on the date stated above.			
22a. SIGNATURE Earl M. Beardsley	22b. DATE SIGNED 12/7/65		
22c. PHYSICIAN'S NAME (Type) Dr. Earl M. Beardsley	22d. ADDRESS Salisbury, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 8. 65.	23c. NAME OF CEMETERY OR CREMATORIAL Wango, Cemetery.	23d. LOCATION (City, town or county) (State) Wango, Md.
24. FUNERAL DIRECTOR Holloway & co.	AODRESS Salisbury, Maryland	25a. REC'D BY REGISTRAR DEC 9 1965	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

20499

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>	c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin rt#3</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Peninsula General Hospital</i>	d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Joseph A. Bridell</i>	First Middle Last	4. DATE OF DEATH Month Year <i>December 12 1965</i>					
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-8-1889</i>	9. AGE (In years last birthday) <i>76 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>10b. KIND OF BUSINESS OR INDUSTRY</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Worcester - Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Elisha Bridell</i>	14. MOTHER'S MAIDEN NAME <i>Laura Brevard</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>16. SOCIAL SECURITY NO.</i>	17. INFORMANT <i>Cordelia Bridell - Berlin Md. rt#3</i>	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332x</i> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>Nov. 21, 1965</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>
20g. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Cerebral Thrombosis</i>	21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 21, 1965</i> , to <i>Dec. 12, 1965</i> , that (I) (we) last saw the deceased alive on <i>Dec. 12, 1965</i> , and that death occurred at <i>12 M</i> , from the causes and on the date stated above.	22a. SIGNATURE <i>Saul J. Salomon</i>	M.D. <input type="checkbox"/> ATTENDING PHYS. 22b. DATE SIGNED <i>Dec. 17, 1965</i>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12-16-65</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>New Bethel</i>	23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>				
24. FUNERAL DIRECTOR <i>Loretta P. Jolley-Jersey Rd. rt#3</i>	ADDRESS <i>Salisbury</i>	25a. REC'D BY REGISTRAR <i>DEC 17 1965</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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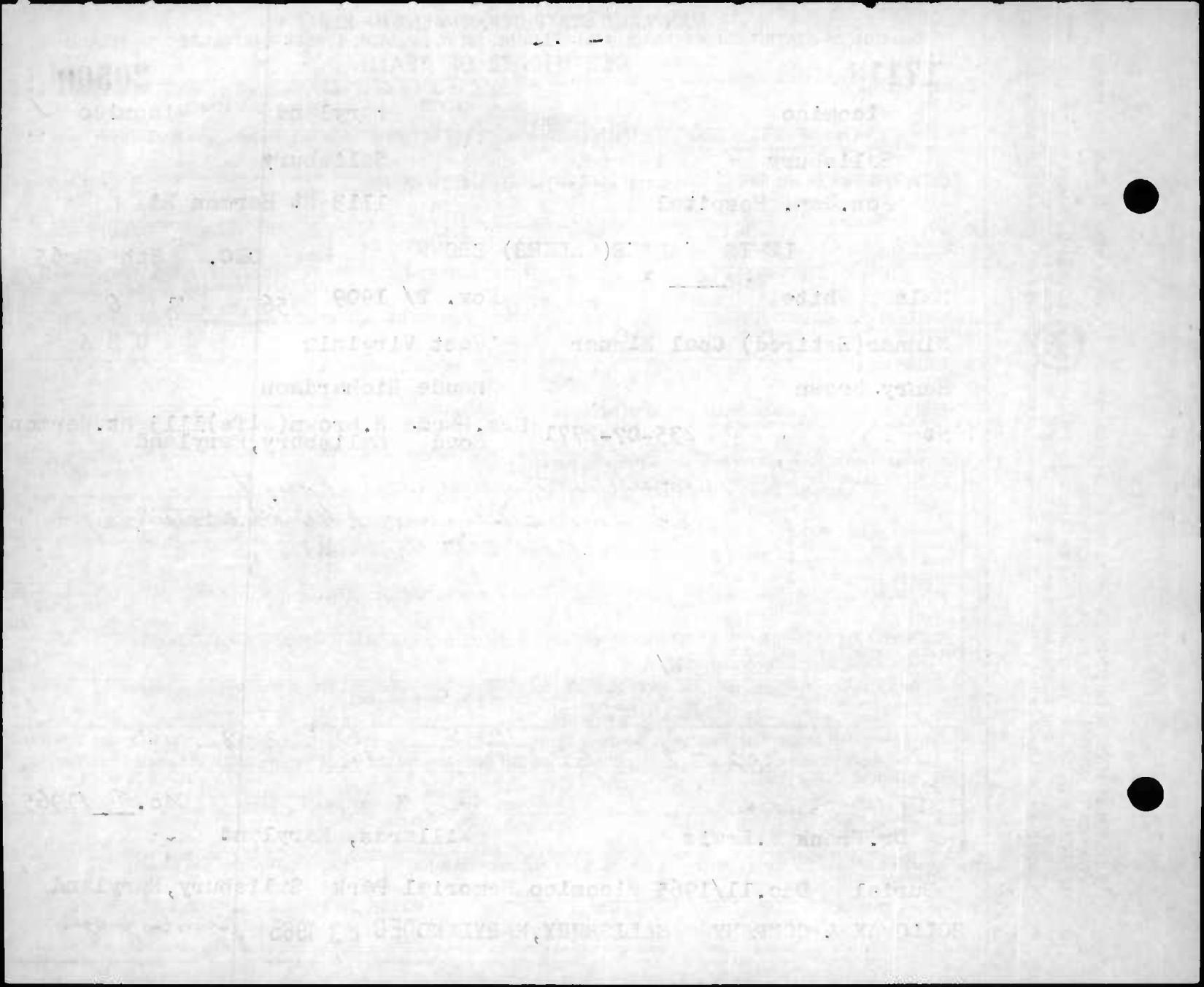
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
17118 24500											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pen. Gen. Hospital											
3. NAME OF DECEASED (Type or print)			First LEWIS	Middle WALTER(WALKER)	Last BROWN	4. DATE OF DEATH	Month DEC.	Day 8th	Year 1965		
5. SEX Male			6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2/ 1909	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 6 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minner(Hired) Coal Minner			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME Henry Brown			14. MOTHER'S MAIDEN NAME Maude Richardson								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No			16. SOCIAL SECURITY NO. 235-07-2771			17. INFORMANT Mrs. Maude M. Brown (Wife) Address 1113 Mt. Hermon Road Salisbury, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5230 right side heart failure secondary to Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) advanced silicosis and bronchitis (c) coal miner from West Virginia 26 yrs. INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) N/A								
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not-White <input type="checkbox"/> p.m. at work <input type="checkbox"/>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not-White <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 12-7, 1965, to 12-8, 1965, that (I) (we) last saw the deceased alive on 12-7 1965, and that death occurred at 291 M, from the causes and on the date stated above.											
22a. SIGNATURE Frank Lewis 22b. DATE SIGNED Dec. 9 / 1965											
22c. PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis			22d. ADDRESS Willards, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Dec. 11/1965			23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park			23d. LOCATION (City, town or county) (State) Salisbury, Maryland		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY			ADDRESS SALISBURY, MARYLAND			25a. REC'D BY REGISTRAR DEC 13 1965			25b. REGISTRAR'S SIGNATURE Charles J. Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 20501

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springhill Private Sanitarium						
3. NAME OF DECEASED (Type or print)	First ETHEL	Middle ALICE	Last CHEATHAM			
4. DATE OF DEATH Month DECEMBER Day 3 Year 1965						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 1/1878			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY None				
13. FATHER'S NAME James G. Gibbes		11. BIRTHPLACE (County & State, or foreign country) Quincy, Florida				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Mrs. Frank Holloway INFORMANT Address 513 N. Pinehurst Ave. Salisbury, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Anderson's atherosic Heart Disease						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral atherosclerosis						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Durham	(County) North Carolina	(State) MD
21. I certify that (I) (this hospital) attended the deceased from 1960 App. 5-15 P.M. to 12-3, 1965 that (II) (we) last saw the deceased alive on 12-3 1965 , and that death occurred at M , from the causes and on the date stated above.				22b. DATE SIGNED Dec. 3 /1965		
22a. SIGNATURE Wilbur R. Ellis, Jr.		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Medical Center Salisbury, Md.			
22c. PHYSICIAN'S NAME (Type) Dr. Wilbur R. Ellis		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Dec. 6/1965 23c. NAME OF CEMETERY OR CREMATORIAL Maplewood Cemetery 23d. LOCATION (City, town or county) (State) Durham, North Carolina				
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND	25a. REC'D BY REGISTRAR DEC 6 1965	25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4th may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

20502

17120			
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
Wicomico MARYLAND		Maryland Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages 1 and 2		c. LENGTH OF STAY IN 1b	
Salisbury		2694 Days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Hurllock 09X2	
Deer's Head State Hospital, Salisbury, Md.			
3. NAME OF DECEASED (Type or print)		First	Middle
George Albert		Last	
4. DATE OF DEATH		Month	Day
Coleman Dec. 26		19	65
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male Negro		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
Retired Owner of Shoe Repair Shop		March 12, 1881	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
84 yrs.		Months	Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country)	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
Retired Owner of Shoe Repair Shop		Dorchester Co., Maryland USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Thomas M. Coleman		Sarah F. Cephas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT	
		214-34-6159 Mrs. Ruby Elbert, Federalsburg, Md., RFD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Hours	
Coronary occlusion			
4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		Years	
Arteriosclerosis			
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/11, 19 50, to 12/26/65, 19 , that (I) (we) last saw the deceased alive on 12/26 19 65 , and that death occurred at 3:20 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 12/27/65	
22a. SIGNATURE		M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS C. F. Gutierrez-Garrido, M.D. Deer's Head State Hospital, Salisbury,	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 30, 1965	
23c. NAME OF CEMETERY OR CREMATORIUM Petersburg Cemetery		23d. LOCATION (City, town or county) Near Hurlock, Maryland (Md.)	
24d. FUNERAL DIRECTOR Lorne Hampton and Son, Federalsburg, Maryland		ADDRESS	
25a. REC'D BY REGISTRAR JAN 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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• *High school students' attitudes towards learning English*

• 201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

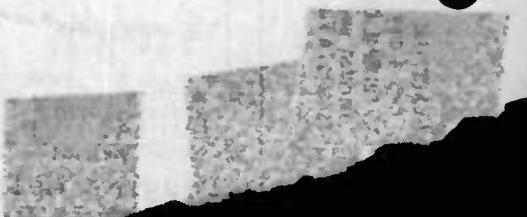
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17121

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence Before admission) a. STATE <u>Delaware</u>	
b. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		b. COUNTY <u>Sussex</u>	
c. LENGTH OF STAY IN 1b		c. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) <u>Frankford</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Rural</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>Eh</u>	Middle <u></u>	Last <u>Collins</u>
4. DATE OF DEATH <u>December 16 1965</u>	Month <u>December</u>	Day <u>16</u>	Year <u>1965</u>
5. SEX <u>Male</u>	6. COLOR DR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVDRCD <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-1894</u>
9. AGE (In years last birthday) <u>71 yrs.</u>	10. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (County & State, or foreign country) <u>DELAWARE</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Levin Collins</u>	14. MOTHER'S MAIDEN NAME <u>Mary Sheppard</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>221-10-1447</u>	17. INFORMANT <u>Agnes Collins, Frankford, Del.</u>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X</u> <i>Carcinoma of the lung & metastasis and pulmonary effusion</i>			
DUE TO (b)		INTERVAL BETWEEN DEATH AND DEATH	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-15, 1965</u> , to <u>12-16, 1965</u> , that (I) (we) last saw the deceased alive on <u>12-16, 1965</u> , and that death occurred at <u>Salisbury</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>James L. Coffey</u>		22b. DATE SIGNED <u>12-16-65</u>	
22c. PHYSICIAN'S NAME (Type)	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-20-65</u>	
23c. NAME OF CEMETERY OR CREMATORIUM <u>Roxana Methodist</u>		23d. LOCATION (City, town or county) (State) <u>Roxana Delaware</u>	
24. FUNERAL DIRECTOR <u>Douglas Nelson Frankford, Delaware</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1965</u>	
ADDRESS <u># 370</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

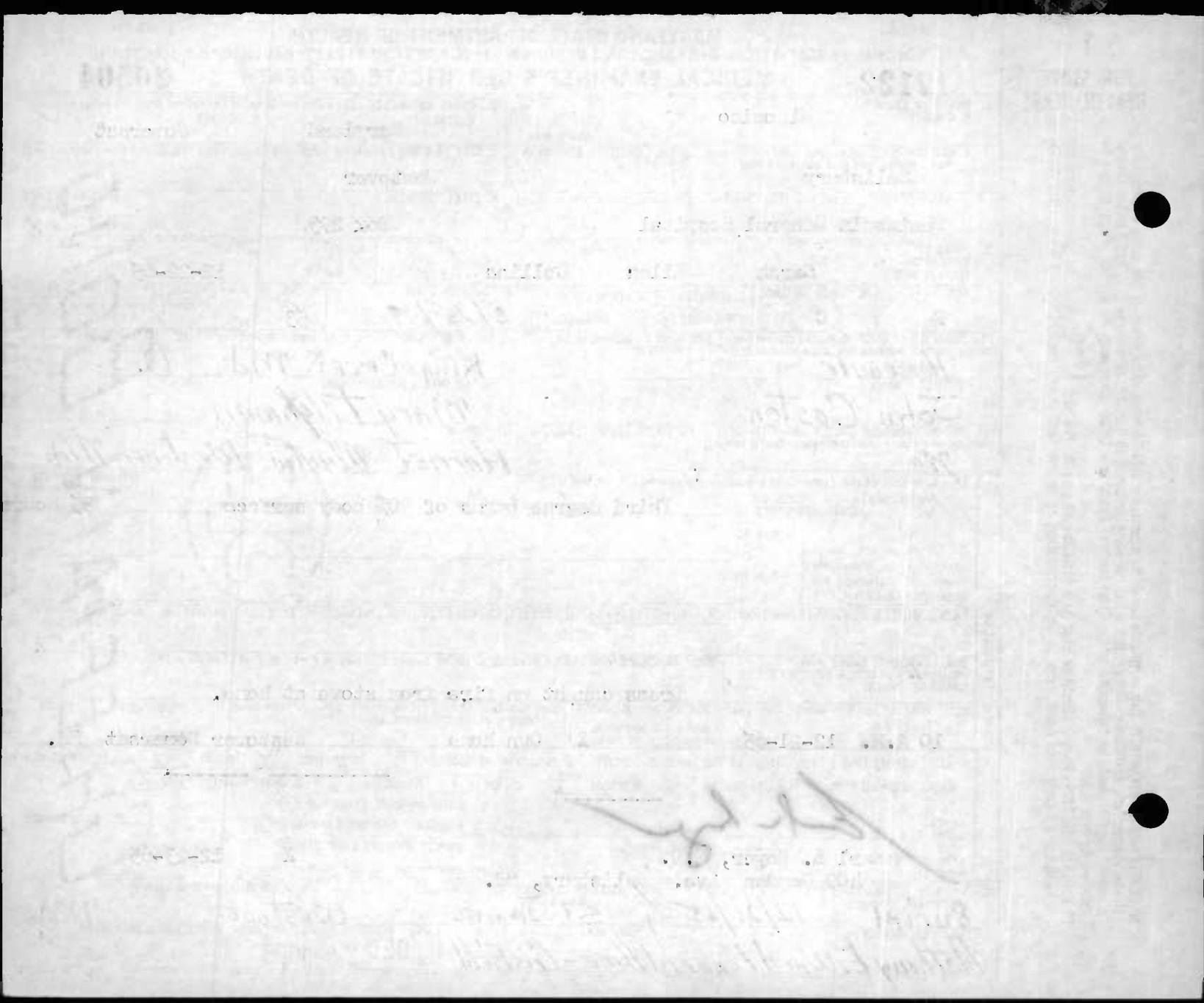
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20504

17122							
1. PLACE OF DEATH a. COUNTY		Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Salisbury		a. STATE Maryland b. COUNTY Somerset			
c. LENGTH OF STAY IN lb					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
					Westover 19 X 2		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Peninsula General Hospital			d. STREET ADDRESS		
					Box 293		
e. IS RESIDENCE ON A FARM?							
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Sarah	Middle Ellen	Last Collins	4. DATE OF DEATH	Month 12-22-65	Day 19 Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months 53 yrs.	IF UNDER 24 HRS Days Hours Min.
F		C	WIDOWED <input checked="" type="checkbox"/> DIVDRCD <input type="checkbox"/>	5/25/1912	53 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)	
Housewife						Kings CREEK Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			12. CITIZEN OF WHAT COUNTRY	
John Coston			Mary Tilghman			U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			Address	
No						Harriet Martin Westover Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Third degree burns of 90% body surface INTERVAL BETWEEN ONSET AND DEATH 35 hours							
9160 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
Dress caught on fire from stove at home.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Own home		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 10 A.M. 12-21-65		20g.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
ACTUAL SIGNATURE							
EXAMINER'S NAME (Type) Earl L. Royer, M.D.							
22. DATE SIGNED 12-23-65							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/26/65		23c. NAME OF CEMETERY OR CREMATOR Y ST JAMES		23d. LOCATION (City, town or county) WESTOVER	
(State) Md.							
24. FUNERAL DIRECTOR Anthony E. Ward Funeral Home - Crisfield ADDRESS							
25a. REC'D BY REGISTRAR DEC 28 1965 25b. REGISTRAR'S SIGNATURE j Charles Judge							
DATE							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please stamp with carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in an event, within 24 hours after death.

17123

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

20505

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE <i>MARYLAND</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Peninsula General Hospital</i>		
3. NAME OF DECEASED (Type or print)		First	Middle	
4. SEX <i>Male</i>	5. COLOR DR RACE <i>White</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDDWED <input type="checkbox"/> DIVDRCED	7. DATE OF BIRTH <i>December 9, 1965</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —		
13. FATHER'S NAME <i>Roland William Cooper</i>		14. MOTHER'S MAIDEN NAME <i>Hilda Mae Donaway</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) — NO		16. SOCIAL SECURITY ND. —		
17. INFORMANT ROLAND WILLIAM COOPER		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity (at 5 oz)</i> 776x Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)				
INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>12-9-</i> , <i>1965</i> , to <i>12-9-</i> , <i>1965</i> , that (I) (we) last saw the deceased alive on <i>12-9</i> , <i>1965</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. SIGNATURE <i>A.C. Mitchell</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12/9/65</i>
22c. PHYSICIAN'S NAME (Type) <i>Dr. A. C. Mitchell</i>		22d. ADDRESS <i>Maryland Ave. Salisbury, Maryland</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 11/1965</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Parsons Cemetery</i>
24. FUNERAL DIRECTOR <i>HOLLOWAY & COMPANY</i>		ADDRESS <i>SALISBURY, MARYLAND</i>		25a. REC'D BY REGISTRAR <i>DEC 13 1965</i>
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If it is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17124

20506

1. PLACE OF DEATH

a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Peninsula General Hosp.

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Dec. 28

1965

5. SEX

6. COLOR OR RACE

Male Negro

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Sept. 17, 1885 80

9. AGE (In years
(At birthday)
yrs.)

IF UNDER 1 YEAR
Months Dey

IF UNDER 24 HRS.
Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

11b. KIND OF BUSINESS OR INDUSTRY

11c. BIRTHPLACE (State or foreign country)

Yardman

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ephoram Coston

14. MOTHER'S MAIDEN NAME

Mary Ginn

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

220-09-1991A Drucilla Coston Pocomoke City, Md.

Address

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

8124

DUE TO

(b)

Shock

DUE TO

(c)

Multifl. comp. part. Fract. Fibula & Femur.

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Pedestrian struck by car

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)
Pocomoke Somerset Md

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

12-28-68

ACTUAL
SIGNATURE

Hugh A. Insley

EXAMINER'S
NAME (Type)

Ph. Hugh A. Insley

Address (Street, city, town, or county)

22e. BURIAL, CREMATION,
REMOVAL (Specify)

22f. DATE THEREOF

Burial 12-31-65

FUNERAL DIRECTOR

22c. NAME OF CEMETERY OR CREMATORIUM

ADDRESS

Georgetown Cem.

22d. LOCATION (City, town, or county) (State)

Pocomoke City, Md.

24e. REC'D BY REGISTRAR

JAN 3 1966

DATE

24b. REGISTRAR'S SIGNATURE

Charles Judge

412-CX-109-24

24-13-W-80

Empire Coal Co. Mary Ginn
Appal. Ky. Wm

No

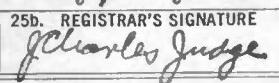
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17125 20507

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.			
3. NAME OF DECEASED (Type or print) Russell Milton Cropper		First Russell Middle Milton Last Cropper	4. DATE OF DEATH Month Dec. Day 2 Year 1965
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking	8. DATE OF BIRTH April 22/1913
9. AGE (in years last birthday) 52 yrs.		11. BIRTHPLACE (County & State, or foreign country) Worcester Co., Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Mott Cropper		14. MOTHER'S MAIDEN NAME Minnie Mitchell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-8123	17. INFORMANT Mrs. Doris P. Cropper (Wife) Address 239 Lincoln Ave (Ext) Salisbury, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant brain tumor (removed)			
1930 DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Salisbury (County) Maryland (State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 30, 1965 to Dec. 2, 1965 , that (I) (we) last saw the deceased alive on Dec. 2, 1965 , and that death occurred at 5:20 A.M. from the causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 12/2/65	
22c. PHYSICIAN'S NAME (Type) C. F. Gutierrez-Garrido, M.D.		22d. ADDRESS Deer's Head State Hospital, Salisbury	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 5/1965	
23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND	
		25a. REC'D BY REGISTRAR DEC 6 1965	25b. REGISTRAR'S SIGNATURE 

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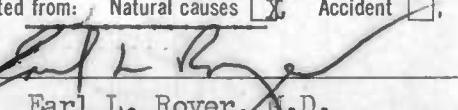
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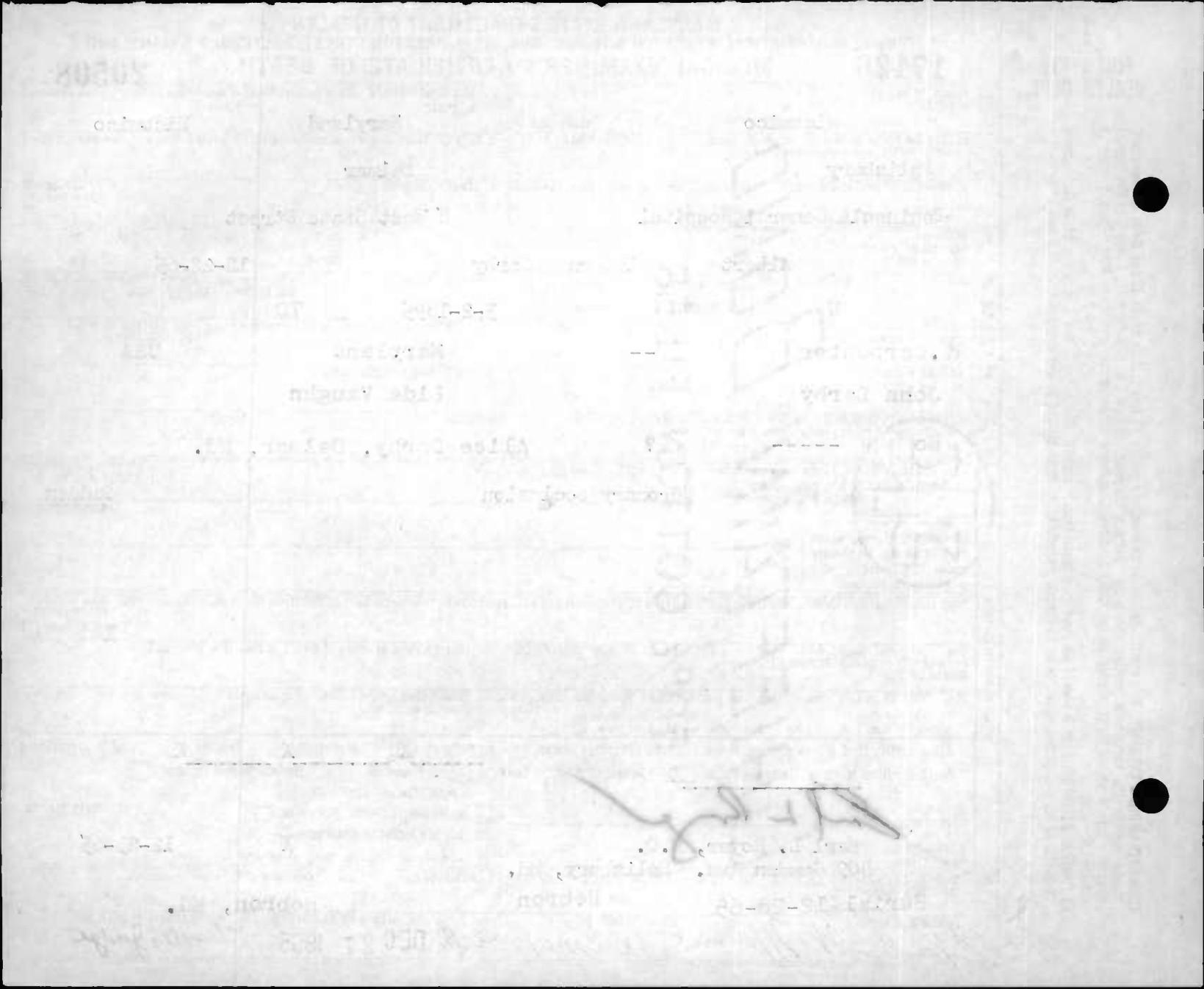
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																
17126				20508												
1. PLACE OF DEATH a. COUNTY			Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			a. STATE Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			b. COUNTY Wicomico										
Salisbury																
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			Peninsula General Hospital			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?							
						8 West State Street			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH			Month	Day	Year					
Albert Melbourn Darby						12-22-65										
5. SEX		6. COLOR OR RACE	7. MARRIED	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)			IF UNDER 1 YEAR		IF UNDER 24 HRS.					
M		W	WIDOWED	<input type="checkbox"/>	DIVORCED	3-2-1895	70 yrs.			Months	Days	Hours				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?							
Rt. Carpenter			--			Maryland			USA							
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			Address										
John Darby			Lida Vaughn			Alice Darby, Delmar, Md.										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFIRMITY			INTERVAL BETWEEN ONSET AND DEATH							
No -----			?			Alice Darby, Delmar, Md.			Sudden							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion																
4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)																
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)																
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)	
Hour a.m. p.m.			19													
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE 																
EXAMINER'S NAME (Type)			Earl L. Royer, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City, town or county)			(State)				
Burial			12-28-65			Hebron			Hebron, Md.							
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Charles W. Jernail, Selmar, Md.						DEC 27 1965			Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17127 CERTIFICATE OF DEATH 20510											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 108 Princeton Ave.						d. STREET ADDRESS 108 Princeton Ave.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED First JOSEPH MIDDLE KENNARD LAST DARDINE, JR.						4. DATE OF DEATH Dec. 23 1965					
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH June 3/1902 9. AGE (In years last birthday) 63 yrs. 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 6 Days 20 Hours 11. BIRTHPLACE (County & State, or foreign country) Phila. Pa.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager Finance 10b. KIND OF BUSINESS OR INDUSTRY Company						12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME Joseph K. Dardine, Sr.						14. MOTHER'S MAIDEN NAME Agnes Dardine Dardine					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. 056-07-9089 17. INFORMANT Mrs. Mary E. Dardine (Wife) 108 Princeton Ave. Salisbury, Md. Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Degenerative Heart Disease</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of item 18.) <i>N/A</i>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19						20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>While at work</i>					
21. I certify that (I) (this hospital) attended the deceased from <i>12/28, 1965</i> , to <i>12/23, 1965</i> , that (I) (we) last saw the deceased alive on <i>12/23, 1965</i> , and that death occurred at M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Wilbur E. Ellis, Jr.</i>						22b. DATE SIGNED <i>Dec. 27/1965</i>					
22c. PHYSICIAN'S NAME (Type) Dr. Wilbur Ellis, Jr.						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.E. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>Medical Center Salisbury, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Dec. 27/1965 23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park						23d. LOCATION (City, town or county) (State) Salisbury, Maryland					
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND						ADDRESS 25a. REC'D BY REGISTRAR DEC 30 1965 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

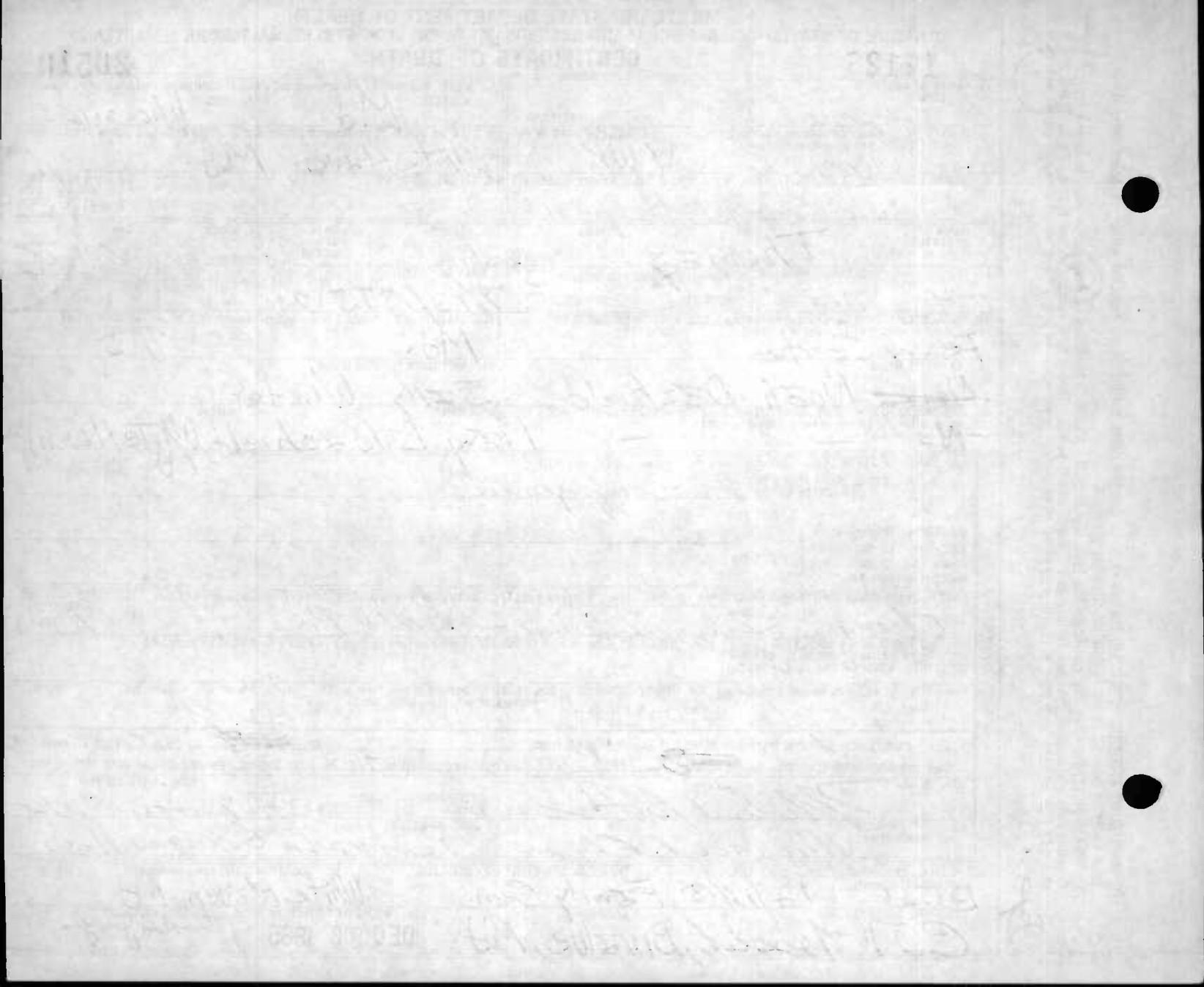
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17128 20510

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Wicomico</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>1 WK</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Peninsula General Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Thomas</i>	Middle <i></i>	Last <i>Dashfield</i>		
4. DATE OF DEATH <i>December 8 1965</i>	Month	Day	Year		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/13/1895</i>	9. AGE (In years last birthday) <i>70 yrs.</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ferry Captain</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (County & State, or foreign country) <i>Md.</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Asa Nash Dashfield</i>		14. MOTHER'S MAIDEN NAME <i>Sally Winder</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> 16. SOCIAL SECURITY NO. <i></i> 17. INFORMANT <i>Mary L. Dashfield, White Haven, Md.</i> Address <i></i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Empyema</i> 518X DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic Lung Disease & old VBC 002.2</i>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i>		20d. INJURY OCCURRED <i>White at work</i> Not White <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Dec 8</i> 20f. (City or town) <i></i> (County) <i></i> (State) <i></i>	
21. I certify that (I) (this hospital) attended the deceased from <i>1965</i> , to <i>1965</i> , that (I) (we) last saw the deceased alive on <i>1965</i> and that death occurred at <i>7P</i> M, from the causes and on the date stated above.					
22a. SIGNATURE <i>Michael B. Flynn</i> 22b. DATE SIGNED <i>Dec 15, 1965</i>					
22c. PHYSICIAN'S NAME (Type) <i>Michael B. Flynn</i>		22d. ADDRESS <i>Peninsula General Hosp</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/12/65</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Family Cem.</i> 23d. LOCATION (City, town or county) <i>White Haven, Md.</i> (State)	
24. FUNERAL DIRECTOR <i>C. J. Messick, Bivalve, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>DEC 20 1965</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17129

CERTIFICATE OF DEATH

20511

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Quantico Road		e. STREET ADDRESS Quantico Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First ELIJAH	Middle LINWOOD	Last DAVIS	4. DATE OF DEATH Month DEC.	Day 26th	Year 1965					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22/ 1902	9. AGE (in years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 10	11. IF UNDER 24 HRS. Days 4	12. IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Groceryman & Poultryman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wicomico Co., Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A					
13. FATHER'S NAME James Thomas Davis		14. MOTHER'S MAIDEN NAME Mary Jane Kelly									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. XXXXXX 212-10-3949		17. INFORMANT Mrs. Mary E.C. Davis (Wife)		Address Quantico Rd Salisbury, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic epidermoid carcinoma INTERVAL BETWEEN ONSET AND DEATH 1919 3 mon.											
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) primary site undetermined											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20d. INJURY OCCURRED at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-15 1965 to App-7:15 P.M. , 19 65 , that (I) (we) last saw the deceased alive on 12-13 1965 , and that death occurred at M. from the causes and on the date stated above.		22b. DATE SIGNED Dec. 28/1965									
22a. SIGNATURE Hubert R. White, Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) Dr. Robert T. Adkins		22d. ADDRESS Fruitland, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 29/1965		23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Mem. Park		23d. LOCATION (City, town or county) (State) Salisbury, Maryland					
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DEC 30 1965		25b. REGISTRAR'S SIGNATURE Charles Judge					

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the details of the model project have been provided.

With your

best regards

Yours sincerely

John

John

John

John

John

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 20512

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) E'en			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS R.F.D. #2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First EVERETT	Middle ALVIN	Last DENSON	4. DATE OF DEATH	Month 12	Day 12	Year 1965
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1929	9. AGE (In years day/birthday) 36 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Baking	10b. KIND OF BUSINESS OR INDUSTRY Rt. Supervisor	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	--	---

13. FATHER'S NAME James E. Denson	14. MOTHER'S MAIDEN NAME Marie Malone
---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 220-28-2228	17. INFORMANT Mrs. Juanita B. Denson, Same	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>		<i>Amidst</i>
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		
DUE TO DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
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20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
---	--	--	--	--	--	--

ACTUAL SIGNATURE <i>Earl L. Royer</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 12-13-1965
---	--	----------------------------------

EXAMINER'S NAME (Type) Dr. Earl L. Royer	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
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DEPUTY MEDICAL EXAMINER

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-15-1965	22c. NAME OF CEMETERY OR CREMATORIUM Siloam Cemetery	22d. LOCATION (City, town, or county) (State) Siloam, Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE Hill Funeral Home	ADDRESS Salisbury, Maryland	24a. REC'D BY REGISTRAR DATE DEC 20 1965	24b. REGISTRAR'S SIGNATURE Charles Judge
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

DEPARTMENT OF HOMELAND SECURITY
FEDERAL BUREAU OF INVESTIGATION

FD-302 (Rev. 1-25-03)

John McLaughlin

John McLaughlin

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17131

CERTIFICATE OF DEATH

20513

be executed within 24 hours after death.

PHYSICIAN: The law requires that the death certificate be signed by the hospital or attending physician.

HOSPITAL OR ATTENDING
Page 4 may be retained by

VR
15M

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
Wicomico				a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		Maryland	
Salisbury		6 days		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		X Mardela Springs		Wicomico	
Deer's Head State Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?	
First Middle Last		Rt 2, Box 70		YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		Month Day Year	
Lula Cindy Deshields		Dec. 14 1965		14 19 65	
5. SEX		6. COLOR OR RACE		7. MARRIED	
Female Colored		NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Domestic		None		11-12-80	
9. AGE (In years last birthday)		10. BIRTHPLACE (County & State, or foreign country)		11. IF UNDER 1 YEAR IF UNDER 24 HRS.	
83 yrs.		Md		Months Days Hours Min.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY	
John Waller		Meruka Jenkins		U.S.A	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
(If yes give war or dates of service)				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		2 weeks			
332X DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		Cerebral thrombosis			
(b) DUE TO		Arteriosclerosis, general			
(c)		Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
19				20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 8, 1965, to Dec. 14, 1965, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 14, 1965, and that death occurred at M, from the causes and on the date stated above.					
22a. SIGNATURE <u>W. Maldve,</u>					
22b. DATE SIGNED 9:30 A.M.					
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.					
22d. ADDRESS Deer's Head Hospital, Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL* (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
Burial		12-18-65		Mardela, Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	
Deakes M. W.				DEC 27 1965	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

Heinrich

Walter Schmid - 1960

15 X 20 \$ 25
original print on paper

oil painting on canvas

1960 100 x 80 cm
signed



Handwritten in pencil:

Franz, micrographia

1 **2**
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17132 20514

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill 23x.2		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Samuel	Middle E	Last Dickerson	
4. DATE OF DEATH December 10, 1965	Month Year	Day	Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. OATE OF BIRTH Sept. 25 1906	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 59 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Chick Hatchery		
11. BIRTHPLACE (County & State, or foreign country) Snow Hill Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Robert E. Dickerson		14. MOTHER'S MAIDEN NAME Alice Duncan		
15. WAS DECEASED EVER IN U.S. ARMEED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. 218-20-3190		
17. INFORMANT Sarah A. Sessions, Snow Hill, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5705 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
INTERVAL BETWEEN ONSET AND DEATH 3 1/2				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Acute Vascular Collaps		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Snow Hill	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 9, 1965 to Dec 10, 1965 , that (I) (we) last saw the deceased alive on Dec 6, 1965 , and that death occurred at 10 AM , from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
22a. SIGNATURE DAVID RH FAT		22b. DATE SIGNED 12/13/65		
22c. PHYSICIAN'S NAME (Type) DAVID RH FAT		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Snow Hill Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-14-65	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Friendship Cemetery	23d. LOCATION (City, town or county) (State) Snow Hill Maryland
24. FUNERAL DIRECTOR Ernest F. Dennis, Snow Hill, Md.		25a. REC'D BY REGISTRAR DEC 15 1965	25b. DATE DEC 15 1965	25c. REGISTRAR'S SIGNATURE Charles Judge

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1960 to 1962

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1960-1961

1961-1962

1962-1963

1963-1964

1964-1965

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17133

CERTIFICATE OF DEATH

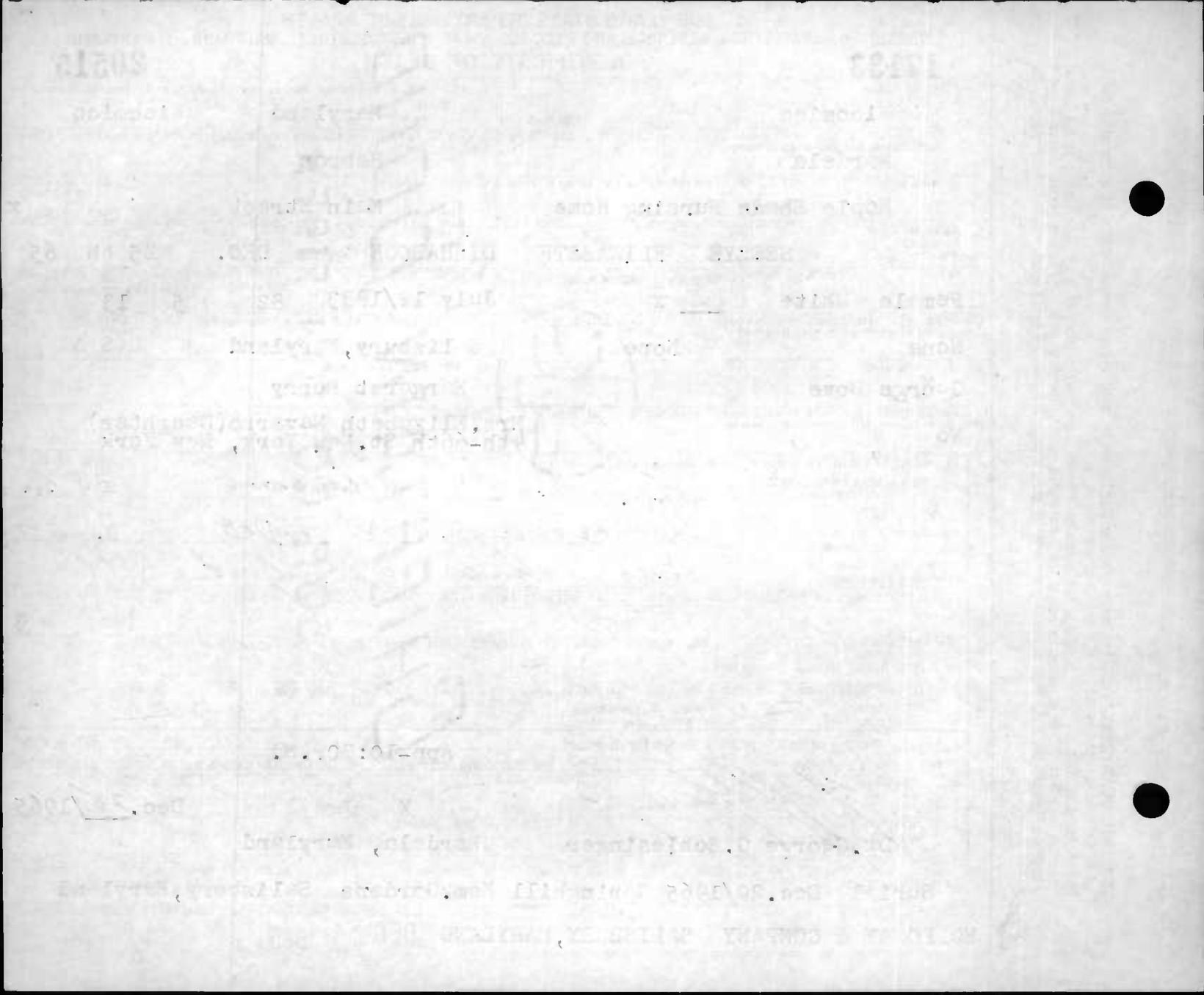
20515

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mardela		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hebron				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Maple Shade Nursing Home		e. STREET ADDRESS Main Street				
3. NAME OF DECEASED (Type or print) BESSYE ELIZABETH DISHAROON		4. DATE OF DEATH Month DEC. Day 25 Year th 1965	IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIOOWEO X	8. DATE OF BIRTH July 12/1883			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR Months 5 Days 13 Hours 00 Min. 00			
13. FATHER'S NAME George Dove		11. BIRTHPLACE (County & State, or foreign country) Salisbury, Maryland				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 0	17. INFORMANT Mrs. Elizabeth Navarro (Daughter) Address 4th-66th St. New York, New York			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis C-A Dis (c) Arteriosclerosis generalized		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 11 mos 3 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Salisbury	(County) Wicomico	(State) Maryland
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on July 12 1965 , and that death occurred at App-10:30 P.M. on Dec. 28 1965 , 19, that (I) (we) last						
22a. SIGNATURE Dr. George G. Schlesinger		22b. DATE SIGNED Dec. 28/1965				
22c. PHYSICIAN'S NAME (Type) Dr. George G. Schlesinger		22d. ADDRESS Mardela, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 29/1965	23c. NAME OF CEMETERY OR CREMATORIAL Springhill Mem. Gardens	23d. LOCATION (City, town or county) (State) Salisbury, Maryland		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND	25a. REC'D BY REGISTRAR REC 30 1965	25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17134

CERTIFICATE OF DEATH

20516

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tyaskin</i>		c. LENGTH OF STAY IN 1b <i>Lifetime</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		X d. STREET ADDRESS <i>R.F.D.</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Arthur C. Fixington</i>		First <i>Arthur</i>	Middle <i>C.</i>
Last <i>Fixington</i>		4. DATE OF DEATH Month <i>12</i>	Day <i>28</i>
5. SEX <i>Male</i>		Month <i>1965</i>	Year
6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/3/1891</i>
9. AGE (In years last birthday) <i>74 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>James Fixington</i>	14. MOTHER'S MAIDEN NAME <i>Unknown</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Esther D. Fixington, Tyaskin, MD.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address <i>INTERVAL BETWEEN ONSET AND DEATH 3 days 2 wks</i>	
PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (e) <i>Pneumonia</i>		DUE TO <i>CVA</i>	
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. <i>Arterio - sclerosis</i>		DUE TO <i>(b)</i>	
		DUE TO <i>(c)</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Bivalve, MD.</i>
20f. (City or town) (County) (State)			
21. I certify that (I) (This hospital) attended the deceased from <i>12/1/65</i> , 19....., to <i>12/28/65</i> , 19....., that (I) (we) last saw the deceased alive on <i>12/28/65</i> , 19....., and that death occurred at <i>9:00 A.M.</i> from the causes and on the date stated above.			
22e. SIGNATURE <i>James J. Kidney</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12/28/65</i>
22c. PHYSICIAN'S NAME (Type) <i>James J. Kidney</i>		22d. ADDRESS <i>Bivalve, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/2/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Newtown Cemetery</i>
23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Charles J. Kidney, Bivalve, Maryland</i>		ADDRESS	25a. REC'D. BY REGISTRAR DATE <i>12/28/56</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles J. Kidney</i>

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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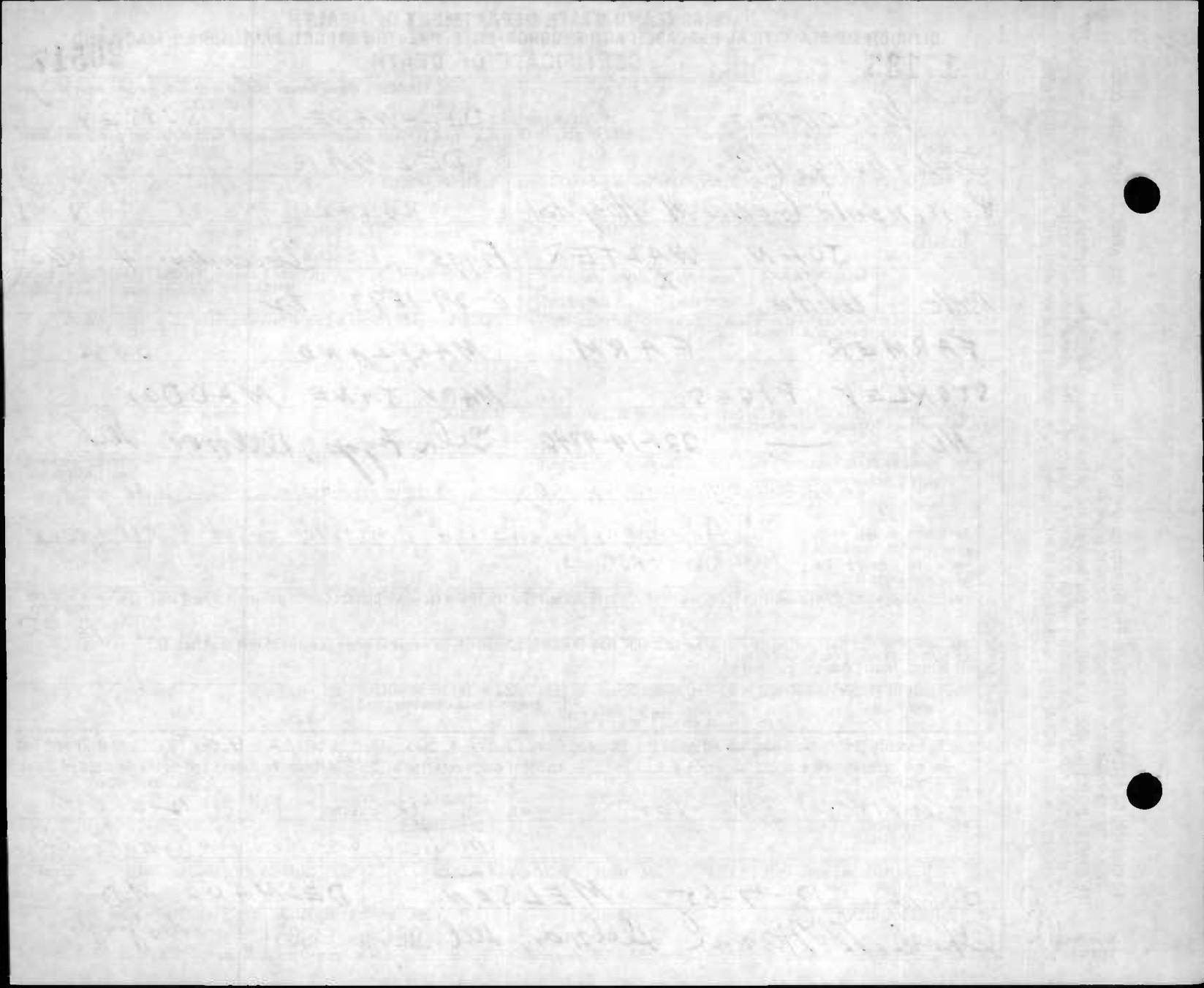
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17135

20517

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Wicomico MARYLAND		b. STATE DELAWARE b. COUNTY SUSSEX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Md.		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS RURAL	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> ND <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOHN	Middle WALTER	Last Figs
4. DATE OF DEATH December 4 1965	Month Year	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-29-1893
9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY FARM	11. BIRTHPLACE (County & State, or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME STANLEY FIGGS	14. MOTHER'S MAIDEN NAME MARY JANE MADDOX	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NC	
16. SOCIAL SECURITY NO. 221-14-4346	17. INFORMANT Sela Figgs, Selmar Sel	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Bronchopneumonia 177X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Adenocarcinoma of prostate with metastases DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
11 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-28-65, 19 to 12-4-65, 19, that (I) (we) last saw the deceased alive on 12-4-65, 19, and that death occurred at 3:30 P.M. from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> ND <input type="checkbox"/>	
22a. SIGNATURE Raymond M. Gay		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12-6-65
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Medical Center Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CEREM		23b. DATE THEREOF 12-7-65	
23c. NAME OF CEMETERY OR CREMATORIUM MELSON		23d. LOCATION (City, town or county) (State) DELMAR - MD	
24. FUNERAL DIRECTOR Charles W. Hammel Selmar, Sel		ADDRESS	25a. REC'D BY REGISTRAR DEC 9 1965
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17136 20518

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>Life Time</u>		b. STATE <u>MARYLAND</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA General HOSPITAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> , 19X-2	
3. NAME OF DECEASED (Type or print) <u>Robert Lee Fisher Jr.</u>		First	Middle	4. DATE OF DEATH Month <u>December</u> , Day <u>1</u> , Year <u>1965</u>	Day <u>Year</u>
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1/21/61</u>	9. AGE (In years last birthday) <u>4 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EMPLOYEE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SUB-DIOPRAGMATIC - ASSCESS-RE- Ruptured Appendix</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Princess Anne, Md</u>	
13. FATHER'S NAME <u>Robert L Fishers</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Hutt</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Ruth Fishers Princess Anne, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EMPLOYEE</u> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <u>5501</u> (b) <u>SUB-DIOPRAGMATIC - ASSCESS-RE-</u> (c) <u>Ruptured Appendix</u>					
INTERVAL BETWEEN DEATH AND DEATH <u>2 days</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>					
22b. MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u></u>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u></u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Md</u>					
21. I certify that (I) (this hospital) attended the deceased from <u>10 AM</u> , 19 <u>65</u> , to <u>Dec 1, 1965</u> , that (I) (we) last saw the deceased alive on <u>December 1, 1965</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>A. Gray Rees</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3 Dec 65</u>	
22c. PHYSICIAN'S NAME (Type) <u>Medical Center, Salisbury, Md</u>		22d. ADDRESS <u></u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/5/65</u>		23c. NAME OF CEMETERY OR CREMATORIES <u>St. Mary</u>	
24. FUNERAL DIRECTOR <u>William H. James Jr.</u> <u>Princess Anne, Md</u>		ADDRESS <u></u>		25a. REC'D BY REGISTRAR <u>REC 6</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
VR A15 (4) 15M 4-64		DATE <u>DEC 6 1965</u>			

6381 320

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
17137				20519									
1. PLACE OF DEATH a. COUNTY Wicomico				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 175 days									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)			First Marian	Middle Elizabeth	Last Floyd	4. DATE OF DEATH December 6 1965	Month December	Day 6	Year 1965				
5. SEX Female		6. COLOR OR RACE Colored	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/15/1905	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Hours	Min. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY VARIOUS				11. BIRTHPLACE (County & State, or foreign country) KENT Co. MARYLAND				12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME JOHN MURRAY				14. MOTHER'S MAIDEN NAME SENIE UNK.									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 214-18-4747				17. INFORMANT MRS V. R. V. IN A CANN				Address Chesterstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4434 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c)													
Years 1964-1965													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Diabetes mellitus													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that 10 (this hospital) attended the deceased from June 14 , 19 65 , to Dec. 6 , 19 65 , that 10 (we) last saw the deceased alive on Dec. 6 , 19 65 , and that death occurred at M , from the causes and on the date stated above.													
22a. SIGNATURE V. Maldve,				22b. DATE SIGNED 11:58 P.M.				22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.					
22d. ADDRESS Deer's Head Hospital, Salisbury, Md.				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22e. DATE 12/7/65					
23a. BURIAL, CREMATION, REMOVAL (Specify) 12/11/65				23b. DATE THEREOF 12/11/65				23c. NAME OF CEMETERY OR CREMATORIAL JANE'S CEMETERY				23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR Charles Judge				ADDRESS Chesterstown, Md.				25a. REC'D BY REGISTRAR DEC 9 1965				25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 (4) 15M 4-64													

192 201/2/51
H-20 KENTCO MFG CO.
7211 E. 2ND AVE.
KANSAS CITY 24

201/2/51 100% 2002 CEMENT
C-46262 LORNA G. HEDSTROM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17138

CERTIFICATE OF DEATH

20520

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar		c. LENGTH OF STAY IN 1b 5 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 211 Spruce Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 211 Spruce			
3. NAME OF DECEASED (Type or print)	First EDITH	Middle EMILY	Last FRERIE	4. DATE OF DEATH Dec. 18, 1965	Month Day Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1897	9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Willard G. Spicer		14. MOTHER'S MAIDEN NAME Mary D. Parker					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-42-8769		17. INFORMANT Irene Culver, 211 Spruce St., Md.		Address Delmar	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO cerebral hemorrhage INTERVAL BETWEEN ONSET AND DEATH 20 min. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO arteriosclerosis retn. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Diabetes mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) While at work					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 211, 19 18 to 1130A, 19		20f. (City or town) (County) (State) Delmar	
21. I certify that (I) (this hospital) attended the deceased from Dec 16 1965 to 19 18 , to dark , 19, that (I) (we) last saw the deceased alive on Dec 16 1965 , and that death occurred at 1130A M, from the causes and on the date stated above.							
22a. SIGNATURE and Dr. Ernest Larmore							
22c. PHYSICIAN'S NAME (Type) Dr. Ernest Larmore		22b. DATE SIGNED 12-20-65					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-21-65		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln,		23d. LOCATION (city, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Charles W. Janel - Delmar, Del.		ADDRESS Charles W. Janel - Delmar, Del.		25a. REC'D BY REGISTRAR DEC 22 1965		25b. REGISTRAR'S SIGNATURE Charles Judge	

05208

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1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

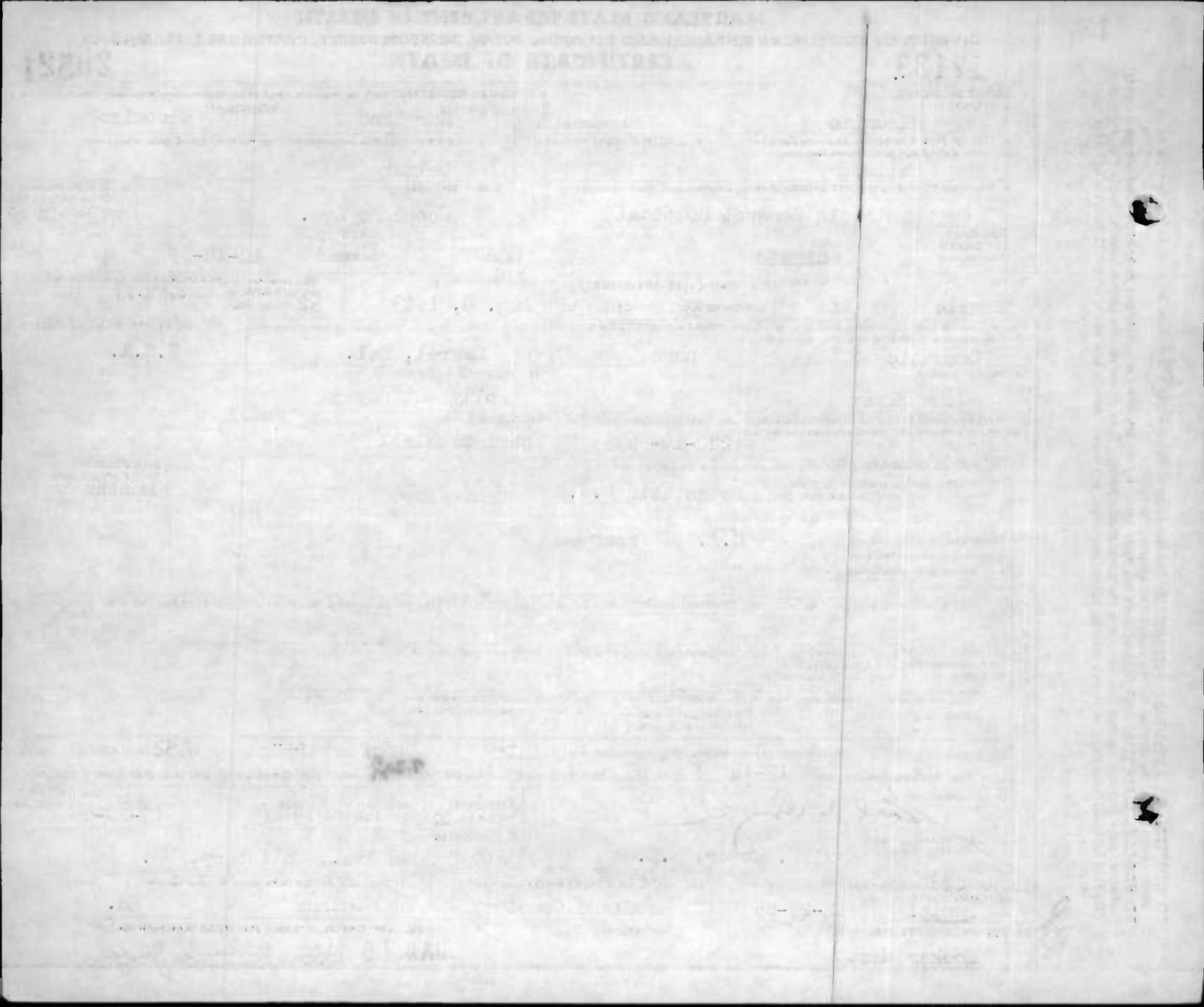
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

20521

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Wicomico	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Delmar			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS Woodland Ave.				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CARRIE		First	Middle	Last	GORDY	4. DATE OF DEATH 12-18-65	Month	Day	Year 19
5. SEX Female		6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1913	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Laurel, Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Elzey		14. MOTHER'S MAIDEN NAME Polly Whitney							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service) No		16. SOCIAL SECURITY NO. 222-10-5435		17. INFORMANT Pearl Dashiell		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH months	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Metastatic G.A.									
157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) C.A. of Pancreas									
DUE TO (c)									
DUE TO (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		Month, Day, Year 8-23	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8-23	20f. (City or town) Delmar	(County) Delmar	(State) Md.		
21. I certify that (I) (this hospital) attended the deceased from..... saw the deceased alive on..... 12-18		19.65		to 12-18	19.65	from the causes and on the date stated above.			
22e. SIGNATURE <i>Earl L. Royer</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12-20-65		
22c. PHYSICIAN'S NAME (Type) Earl L. Royer, M.D.		22d. ADDRESS 409 Camden Ave., Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-23-65	23c. NAME OF CEMETERY OR CREMATORIAL Woodland Cemetery		23d. LOCATION (City, town or county) Delmar		(State) Md.		
24 FUNERAL DIRECTOR'S SIGNATURE Booker West		ADDRESS		25a. REC'D BY REGISTRAR JAN 10 1966		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17140		201522	
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>VIRGINIA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		b. COUNTY <i>Accomack</i>	
c. LENGTH OF STAY IN 1b <i>10 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>GREENBACKVILLE 82X-3</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Peninsula General Hospital</i>		d. STREET ADDRESS —	
3. NAME OF DECEASED (Type or print) <i>Harry TURNER SIDNEY Hart</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH <i>December 3 1965</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MARCH 14 1879</i>
9. AGE (In years last birthday) <i>86 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FREIGHT AGENT</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>RAILROAD</i>	11. BIRTHPLACE (County & State, or foreign country) <i>PENNSYLVANIA</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13. FATHER'S NAME <i>UNKNOWN</i>		
14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>UNKNOWN</i>	
16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT <i>MRS LEROY MOORE, 1926 RISING SUN LANE, WILMINGTON, DELAWARE</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332x</i>		Address INTERVAL BETWEEN ONSET AND DEATH <i>app 13 days</i>	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Thrombosis</i>		DUE TO (c) <i>Cerebrovascular Atherosclerosis.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>JAMES L. CLIFFORD, m.d.</i>
20f. (City or town) <i>Salisbury</i>		(County) (State) <i>Worcester County, Maryland</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>11-23</i> , 19 <i>65</i> , to <i>12-3</i> , 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>12-3 1965</i> , and that death occurred at <i>12-3 1965</i> M, from the causes and on the date stated above.		22a. SIGNATURE <i>James L. Clifford</i>	
22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>JAMES L. CLIFFORD, m.d.</i>		22d. ADDRESS <i>Medical Center Salisbury Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>12-8-1965</i>	23c. NAME OF CEMETERY OR CINERATORIUM <i>UNION GREENBACKVILLE</i>
24. FUNERAL DIRECTOR <i>Robert H. Watson</i>		23d. LOCATION (City, town or county) (State) <i>WORCESTER County, MARYLAND</i>	
ADDRESS <i>Pocomoke City, MD.</i>		25a. REC'D BY REGISTRAR <i>DEC 10 1965</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

55215

55215

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "Pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17141 20523

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b c. STREET ADDRESS R.D.#3 Old Zion Church Rd., Salisbury, Md.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospital		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) SAMUEL GORDON HEARNE		First Middle Last	4. DATE OF DEATH X DEC. 23 1965			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24/1913			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	9. AGE (in years last birthday) 52 yrs.			
11. BIRTHPLACE (State or foreign country) Wicomico Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	10. IF UNDER 1 YEAR Months 3 Days 29 Hours 0 Min. 11. IF UNDER 24 HRS.			
13. FATHER'S NAME Theodore Samuel Hearne		14. MOTHER'S MAIDEN NAME Etta White				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Mrs. Mabel Truitt Hearne (Wife)				
17. INFORMANT R.D.#3 Zion Church Rd., Salisbury, Md.		Address Coronary Occlusion				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 4201 Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH Minutes				
DUE TO Conditions, If any, which gave rise to immediate cause (e), stating the underlying cause last. (b) N/A		DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury, Md.	20f. (City or town) Salisbury, Md.	(County) Wicomico Co.	(State) Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22. DATE SIGNED Dec. 27 /1965						
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial Dec. 28/65		23c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		23d. LOCATION (City, town or county) Salisbury, Maryland		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND		ADDRESS		25a. REC'D BY REGISTRAR DEC 28 1965	25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17142

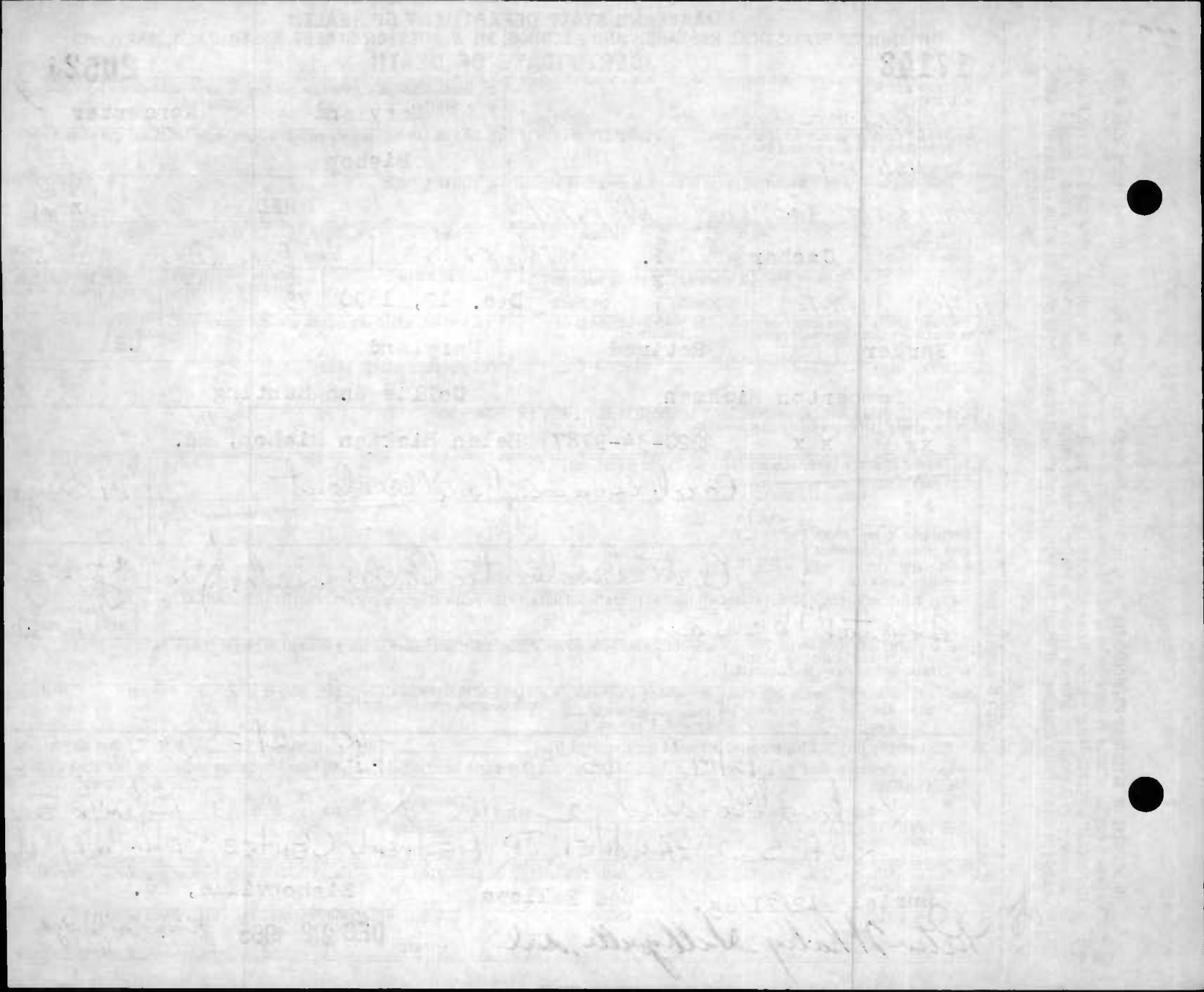
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

20524

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Worcester</i>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bishop</i>		d. STREET ADDRESS <i>RFD</i>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsula General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Cashar</i>	Middle <i>F.</i>	Last <i>Hickman</i>	4. DATE OF DEATH <i>December 18 1965</i>	Month <i>Dec.</i>	Day <i>18</i>	Year <i>1965</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 12, 1890</i>	9. AGE (In years (last birthday) <i>75</i> yrs.	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>Pemberton Hickman</i>	14. MOTHER'S MAIDEN NAME <i>Dollie Ann Bunting</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>XX</i>	16. SOCIAL SECURITY NO. <i>X X 220-34-9787</i>	17. INFORMANT <i>Helen Hickman Bishop, Md.</i>	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4221</i>		DUE TO (b) DUE TO (c) <i>Cerebrovascular Accident</i>		INTERVAL BETWEEN ONSET AND DEATH <i>14 days</i>				
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetic Hernia</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Bishopville</i>	(County) <i>Md.</i>	(State) <i>MD</i>			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 19____, that (I) (we) last saw the deceased alive on 12/17 1965, and that death occurred at 12/21 1965, M, from the causes and on the date stated above.				22a. SIGNATURE <i>Rufus S. Gardner, Jr.</i>	M.O. ATTENDING PHYS. <i>X</i>	M.D. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	
22b. DATE SIGNED <i>12/18/65</i>	22d. ADDRESS <i>MEDICAL CENTER, SALISBURY, MD.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12/21/65</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Odd Fellows</i>	23d. LOCATION (City, town or county) <i>Bishopville, Md.</i>	(State)				
24. FUNERAL DIRECTOR <i>Titen Whaley, Salisbury, Md.</i>	AODRESS	25a. REC'D BY REGISTRAR <i>DEC 22 1965</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

20525

17143		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)																	
a. COUNTY Wicomico		a. STATE Maryland b. COUNTY Wicomico																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b																	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 610 S.Division St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) ADA ANNIE HOLLOWAY		First	Middle	Last	4. DATE OF DEATH DEC. 30	Month	Day	Year	19	65									
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 9/1879	9. AGE (In years last birthday) 86 yrs.	10. KIND OF BUSINESS OR INDUSTRY Retired Shirt Factory "Operator"	11. BIRTHPLACE (County & State, or foreign country) Delmar, Delaware	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME George Hastings	14. MOTHER'S MAIDEN NAME Mary Hastings Hastings									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Frances B. Parker (Foster-Daughter) 610 S.Division St. Salisbury, Md.		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 4201 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>years</u>				INTERVAL BETWEEN ONSET AND DEATH 2 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Parsonsburg		(County) Maryland		(State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1965</u> to <u>Dec 30, 1965</u> , that (I) (we) last saw the deceased alive on <u>Dec 1, 1965</u> , and that death occurred at <u>Parsonsburg, Maryland</u> M, from the causes and on the date stated above.												22b. DATE SIGNED Dec. 31 / 1965							
22a. SIGNATURE <u>Robert T. Adkins</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS Fruitland, Maryland															
22c. PHYSICIAN'S NAME (Type) Dr. Robert T. Adkins		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE THEREOF Jan. 3/1965		23c. NAME OF CEMETERY OR CREMATORIAL Forest Grove Cemetery		23d. LOCATION (City, town or county) Parsonsburg, Maryland		(State)	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND		ADDRESS										25a. REC'D BY REGISTRAR JAN 3 1966		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>		DATE			

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Item 20a-20f Film G372 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND1
FOR STATE
HEALTH DEPT.

17144

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1/13/66 TT

20526

1. PLACE OF DEATH

e. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Salisbury

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Peninsula General Hosp.

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Dec.

27

1965

5. SEX

6. COLOR OR RACE

Male Negro

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Dec. 1, 1907 58

9. AGE (In years
last birthday)
yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer Factory

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Cornish

14. MOTHER'S MAIDEN NAME

Mary Horsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes give war or dates of service

No

16. SOCIAL SECURITY NO.

—

17. INFORMANT

Mary Horsey Pocomoke City, Md.
Cemphound Fracture ShoulderINTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

8134

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Fract left tibia & fibula

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Struck by car while on Bicycle

20c. TIME OF INJURY Month, Day, Year
Hour **X**.
7:05 p.m. 12/27/6520d. INJURY OCCURRED
While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Rt 13 nr. Pocomoke Pocomoke Wicomico Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner ACTUAL
SIGNATURE

Phylga Dealey

CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

12-28-65

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial22b. DATE THEREOF
1-2-66

22c. NAME OF CEMETERY OR CREMATORIUM

Friendship Cem.

22d. LOCATION (City, town, or country)

Wattsburg, Va.

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Samuel Savage New Church, Va. JAN 3 1966 Charles Judge

IV

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17145 20527

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 23 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.		d. STREET ADDRESS 228 Delaware Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Alice	Middle Elsie	Last Jones
4. DATE OF DEATH Dec. 22 1965	Month Day Year		
5. SEX Female	6. CDLR DR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 6, 1900
9. AGE (In years last birthday) 65 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS DR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Henry Jones	14. MOTHER'S MAIDEN NAME Annie Dashiell	Address Salis Ma Minnie Cottman 102 Catherine St.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 17. INFORMANT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of cervix uteri with metastases			
17145 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/29 , 1965, to 12/22 , 1965, that (I) (we) last saw the deceased alive on 12/22 , 1965, and that death occurred at 12:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE V. Juerman			
22b. DATE SIGNED 12/22/65			
22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D.			
22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/26/1965	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Green Acres
24. FUNERAL DIRECTOR Walter E. Stewart, Sales M.D.		23d. LOCATION (City, town or county) (State) Salisbury Md.	
25a. REC'D BY REGISTRAR REC 29 1965		25b. REGISTRAR'S SIGNATURE Charles Judge	

recommend date from which an option

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY Wicomico				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland				20528				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 42 Y rs.				b. COUNTY Wicomico				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1104 Riverside Dr.,				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) LOUIS			First —	Middle —	Last KLEGER	4. DATE OF DEATH 12 3 1965	Month 12	Day 3	Year 1965			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1900	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	IF UNDER 24 HRS. Minutes 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocers Retail			10b. KIND OF BUSINESS OR INDUSTRY Store Owner	11. BIRTHPLACE (County & State, or foreign country) Moscow RUSSIA			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Samuel Kleger			14. MOTHER'S MAIDEN NAME Unknown									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. Y S	17. INFORMANT Mrs. Louis Kleger, Same	Address							
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)			INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 4201			<i>Myocardial Infarction</i>									
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause first. (b)			<i>Coronary artery disease</i>									
DUE TO (c)			5 yrs									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Allee 3	(County) Salisbury	(State) Maryland	20g. DATE 1965				
21. I certify that (I) (this hospital) attended the deceased from to , 1965, that (I) (we) last saw the deceased alive on , 1965, and that death occurred at A.M., from the causes and on the date stated above.												
22a. SIGNATURE William D. Gray			M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12-3-1965			
22c. PHYSICIAN'S NAME (Type) Dr. William D. Gray			22d. ADDRESS 334 Camden Ave., Salisbury, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12-3-1965	23c. NAME OF CEMETERY OR CREMATORIAL Beth Israel Cemetery	23d. LOCATION (City, town or county) Salisbury, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Sol Levinson Bros. Inc. 6010 Reisterstown Rd			ADDRESS 6010 Reisterstown Rd	25a. REC'D BY REGISTRAR DEC 9 1965	25b. REGISTRAR'S SIGNATURE Charles Judge							
VR A15 41 20M 5-63												

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To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
Item #8 Film 70371 17147 1939-2 20529													
1. PLACE OF DEATH a. COUNTY		Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Salisbury				c. LENGTH OF STAY IN 1b		a. STATE Maryland					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Deer's Head State Hospital, Salisbury, Md.				b. COUNTY Somerset		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield					
3. NAME OF DECEASED (Type or print)		First Ola	Middle B.	Last Landon	4. DATE OF DEATH Dec. 5 19 65		d. STREET ADDRESS 334 Cove St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 14, 1898	9. AGE (In years last birthday) 67 yrs.	10. KIND OF BUSINESS OR INDUSTRY Seafood Worker	11. BIRTHPLACE (County & State, or foreign country) Crisfield, Maryland	12. CITIZEN OF WHAT COUNTRY? USA	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Seafood		14. MOTHER'S MAIDEN NAME Anna Horner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Ralph Landon, Same as 2. abcd		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Bronchopneumonia 5 days											
331X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	Recurrent cerebral vascular accident 5 days										
		DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 9/17, 1964 to 12/5, 1965, that (I) (we) last saw the deceased alive on 12/5 1965, and that death occurred at 3:00 P.M. from the causes and on the date stated above.													
22a. SIGNATURE <i>V. Juerman</i>		22b. DATE SIGNED 12/6/65											
22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/8/65		23c. NAME OF CEMETERY OR CREMATORIUM Asbury Cemetery		23d. LOCATION (City, town or county) Crisfield, Maryland		(State)					
24. FUNERAL DIRECTOR		ADDRESS Bradshaw & Sons, Crisfield, Maryland		25a. REC'D BY REGISTRAR DEC 10 1965		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17168 20530
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Dorchester</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>	c. LENGTH OF STAY IN 1b 2 Days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Peninsula General Hospital</i>						
3. NAME OF DECEASED (Type or print) <i>Hattie</i>	First <i>L</i> Last <i>Lamkford</i>	Middle <i>Waters</i>	4. DATE OF DEATH Month <i>December</i> Day <i>10</i> Year <i>1965</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>February 22, 1896</i>	9. AGE (in years last birthday) <i>69 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Dorchester County, Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>George Marine</i>	14. MOTHER'S MAIDEN NAME <i>Margaret Fisher</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>217-36-0518</i>	17. INFORMANT <i>Leon L. Lamkford, Rhodesdale, Md. R.F.D.</i>	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure and</i> <i>4200</i> DUE TO <i>Pulmonary Edema</i> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>26 Years</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus and Nephropathy.</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>12/9/1965</i>	20f. (City or town) <i>12/9/1965</i>	(County) (State) <i>Rhodesdale</i>		
21. I certify that (I) (this hospital) attended the deceased from <i>12/9/1965</i> to <i>12/10/1965</i> , that (I) (we) last saw the deceased alive on <i>12/9/1965</i> , and that death occurred at <i>12/9/1965</i> M, from the causes and on the date stated above.						
22a. SIGNATURE <i>J. J. Frampton</i>	22b. DATE SIGNED <i>12/10/1965</i>					
22c. PHYSICIAN'S NAME (Type) <i>J. J. Frampton and Son</i>	M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>Federalsburg, Md</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12/14/65</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Galestown Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Galestown, Maryland</i>			
24. FUNERAL DIRECTOR <i>J. J. Frampton and Son, Federalsburg, Md</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>DEC 20 1965</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

20531

1. PLACE OF DEATH a. COUNTY Wicomico			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland			b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 15 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden			d. STREET ADDRESS Route # 1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Alice	Middle Mae	Last Marshall	4. DATE OF DEATH Dec. 29 1965	Month Dec.	Day 29	Year 1965			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 18, 1886	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME SIDNEY C. DRYDEN			14. MOTHER'S MAIDEN NAME SALLIE BRITTINGHAM								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address		
						MRS WALTER HALE PRINCESS ANNE, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia											
332X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Cerebral thrombosis with right hemiparesis and motor aphasia (c) DUE TO											
6 weeks											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Diabetes mellitus											
INTERVAL BETWEEN ONSET AND DEATH 2 days											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Dec. 14, 1965, to Dec. 29, 1965, that (I) (we) last saw the deceased alive on Dec. 29, 1965, and that death occurred at M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Juerman</i>						3:35 P.M.			22b. DATE SIGNED 12/29/65		
M.D. ATTENDING PHYS.			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								
22c. PHYSICIAN'S NAME (Type) V. Juerman, M.D.			22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 1/1/1966			23c. NAME OF CEMETERY OR CREMATORIUM ST. ANDREW CEMETERY			23d. LOCATION (City, town or county) (State) PRINCESS ANNE, MD.		
24. FUNERAL DIRECTOR LEVIN R. WILSON PRINCESS ANNE, MD.			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE J. Charles Judge		
VR A15 (4) 15M 4-64						DATE JAN 4 1966					

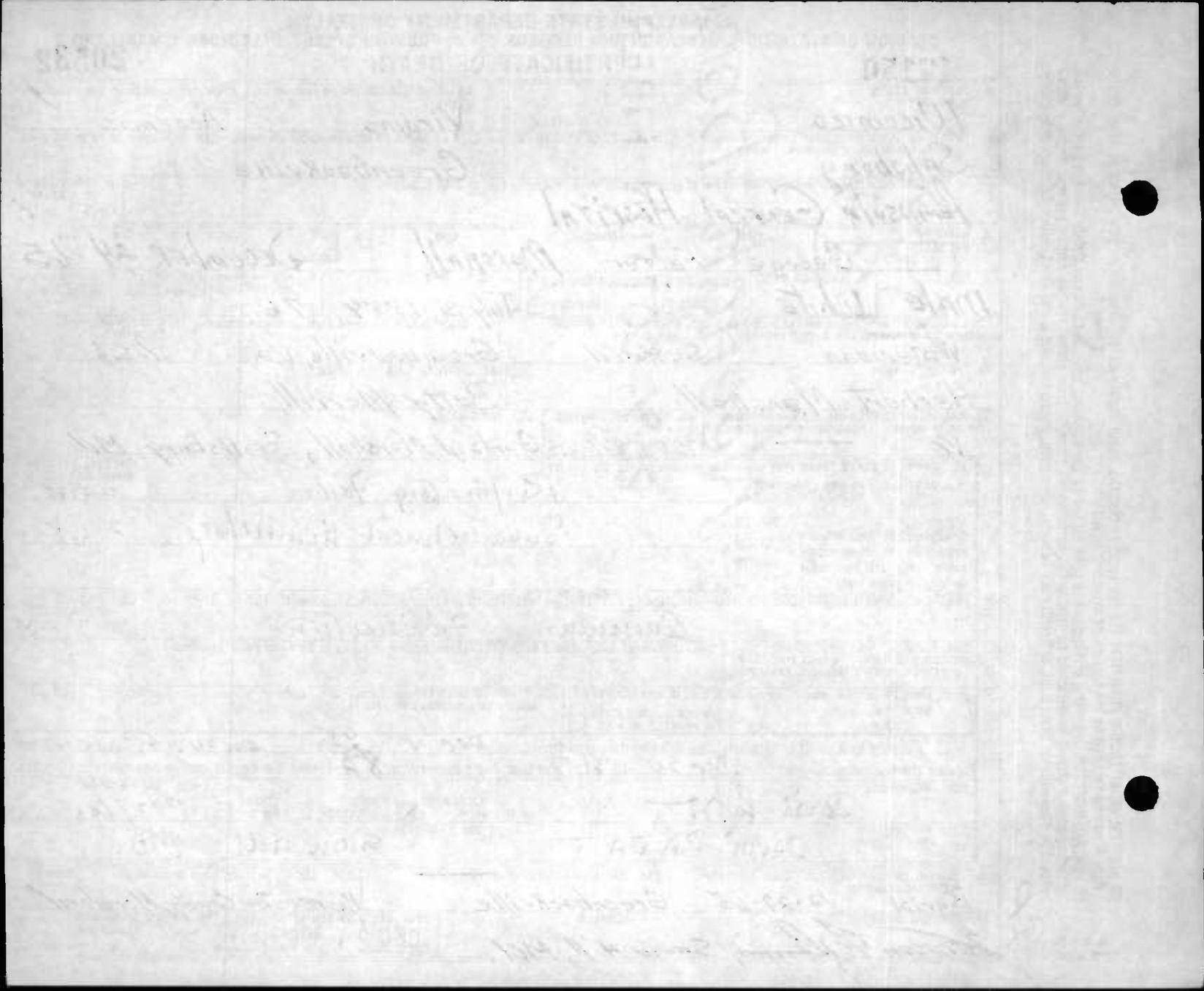
1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17150		20532											
1. PLACE OF DEATH a. COUNTY <i>Accomico</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Virginia</i>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		b. COUNTY <i>Accomac</i>											
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greenbackville 83x3</i>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Peninsula General Hospital</i>		d. STREET ADDRESS											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <i>George Felter MARSHALL</i>		First	Middle	Last	4. DATE OF DEATH <i>DECEMBER 24 1965</i>	Month	Day	Year					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 31 1889</i>	9. AGE (In years last birthday) <i>76 yrs.</i>	IF UNDER 1 YEAR Months	Odays	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Seafood</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Greenbackville, Va.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>						
13. FATHER'S NAME <i>Herbert Marshall</i>		14. MOTHER'S MAIDEN NAME <i>Betty Merrill</i>		Address									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>230-18-0213</i>		17. INFORMANT <i>Garland Marshall, Salisbury, Md.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>26 days</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>330X</i>		DUE TO (b)		Respiratory Failure									
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Subarachnoid Hemorrhage</i>		DUE TO (c)		Subarachnoid Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Auricular fibrillation</i>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) <i>Dec 10, 1965, to Dec 24, 1965</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Snow Hill</i>		(County) <i>Worcester County</i>		(State) <i>Maryland</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 24, 1961</i> , to <i>Dec 24, 1965</i> , that (I) (we) last saw the deceased alive on <i>Dec 24, 1961</i> , and that death occurred at <i>8 AM</i> , from the causes and on the date stated above.													
22a. SIGNATURE <i>David Rapt</i>													
22c. PHYSICIAN'S NAME (Type) <i>Jarin RAPT</i>		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <i>Snow Hill</i>		M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12/27/65</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-27-65</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Greenbackville</i>		23d. LOCATION (City, town or county) <i>Worcester County, Maryland</i>		(State)					
24. FUNERAL DIRECTOR <i>Edmund F. Flemming, Snow Hill, Md.</i>		25a. REC'D BY REGISTRAR <i>DEC 29 1965</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE							



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FOR STATE
HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Part 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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If any part necessary,
please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director.
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

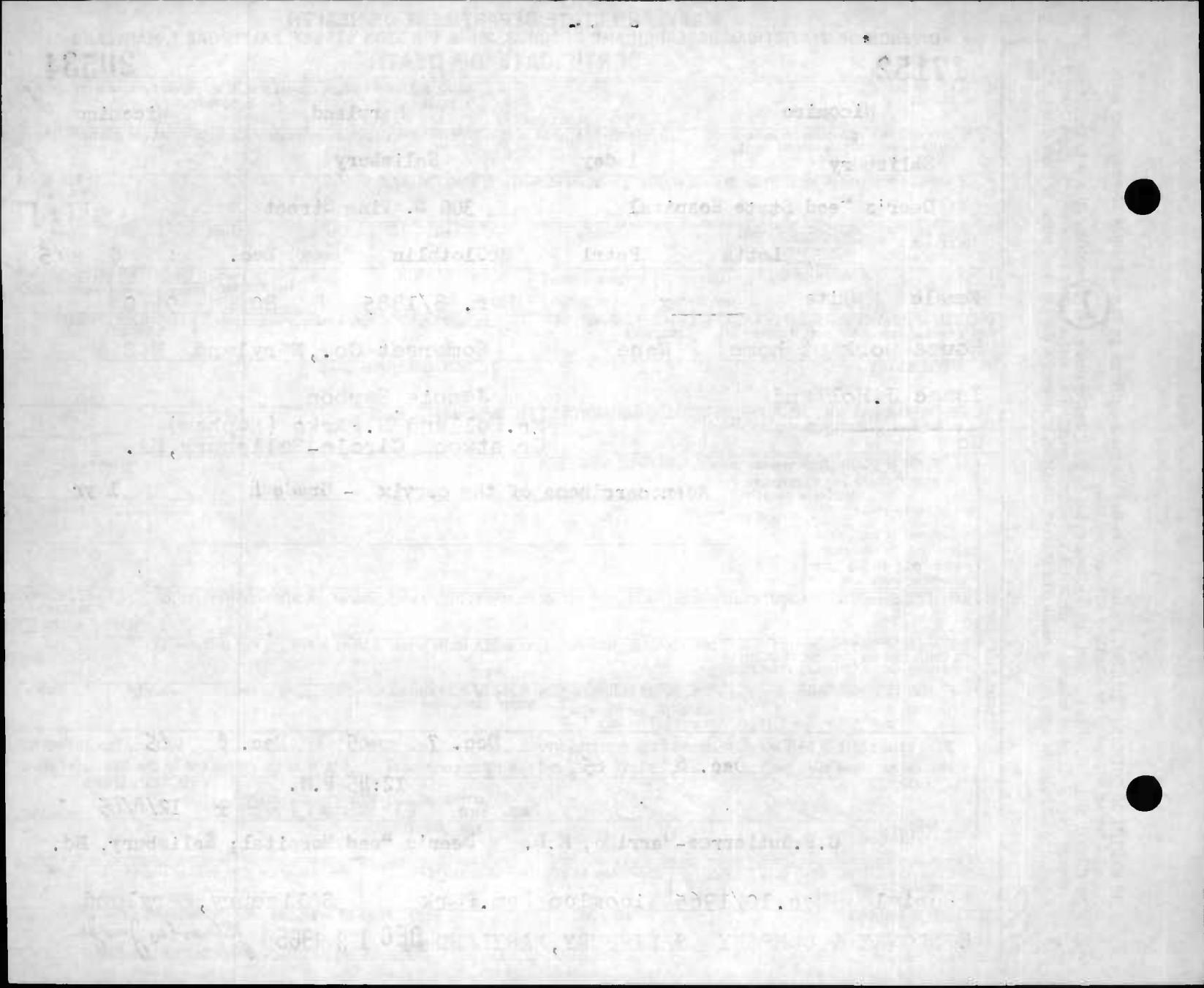
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17152

20534

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Salisbury 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				d. STREET ADDRESS 300 E. Vine Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First Lotta	Middle Pearl	Last McGlothlin	4. DATE OF DEATH Month Dec. Day 8 Year 1965	Month Dec. Day 8 Year 1965	Month Dec. Day 8 Year 1965	Month Dec. Day 8 Year 1965
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 8/1885	9. AGE (in years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 9	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work at home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Isaac J. Holland				14. MOTHER'S MAIDEN NAME Jennie Barbon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Holland S. Parks (Nephew)	Address Crestwood Circle-Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the cervix - Grade 4				INTERVAL BETWEEN ONSET AND DEATH 1 yr			
171X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Deer's Head Hospital	(County) Salisbury	(State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from Dec. 7, 1965 , to Dec. 8, 1965 , that (I) (we) last saw the deceased alive on Dec. 8, 1965 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE <i>C.F. Gutierrez-Garrido, M.D.</i>				12:45 P.M.	22b. DATE SIGNED 12/8/65		
22c. PHYSICIAN'S NAME (Type)	M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						
22d. ADDRESS Deer's Head Hospital, Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 10/1965	23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Mem. Park	23d. LOCATION (City, town or county) Salisbury	(State) Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY	ADDRESS SALISBURY, MARYLAND	25a. REC'D BY REGISTRAR DEC 13 1965	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

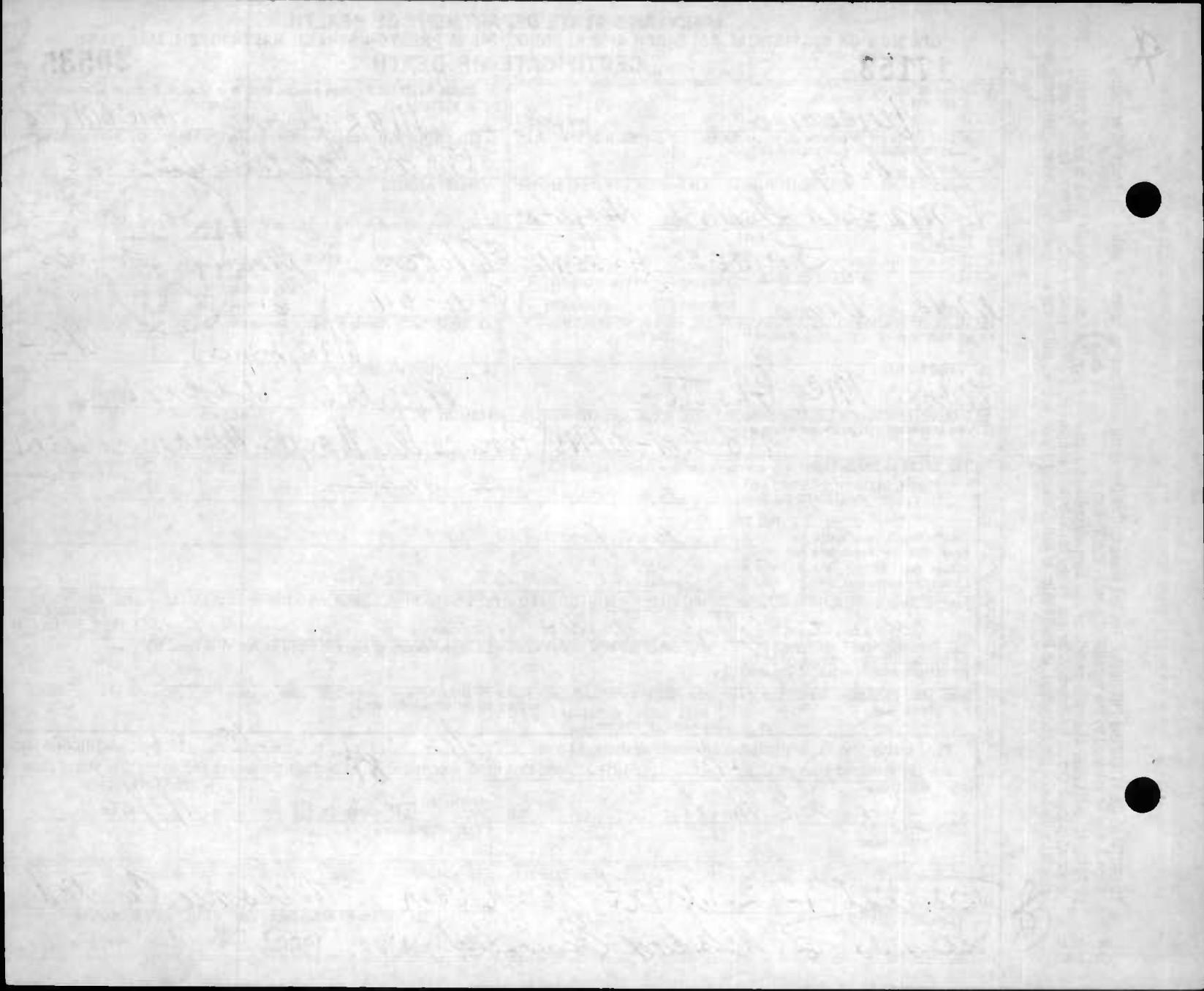
Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17153 20535

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Wicomico	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Marlboro Springs			
3. NAME OF DECEASED (Type or print) JAMES ANDREW MC GLOTHEN		First	Middle	Last		4. DATE OF DEATH December 30 1965	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-11-04	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR <input type="checkbox"/>	IF UNDER 24 HRS <input type="checkbox"/>	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Wm. Mc Glothen		14. MOTHER'S MAIDEN NAME Myrtle - unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-07-148		17. INFORMANT Peninsula Hosp. Wicomico Co. Md.		Address		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia and shock									
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia									
DUE TO (c) External bronchial secretions									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Postoperative Pusper & Miller lobectomy for carcinoma of lung									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Wicomico Co. Md.		(County) Wicomico Co. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 12/12 1965 to 12/30 1965 , that (I) (we) last saw the deceased alive on 12/30 1965 , and that death occurred at 89 M, from the causes and on the date stated above.									
22a. SIGNATURE Richard E Hughes									
22c. PHYSICIAN'S NAME (Type) James B. Klaisted Easton, Md.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/3/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1-2-66 Mt. Zion Cem.		23b. DATE THEREOF 1-2-66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Zion Cem.		23d. LOCATION (City, town or county) Wicomico Co. Md.		(State)	
24. FUNERAL DIRECTOR James B. Klaisted Easton, Md.		ADDRESS DATA		25a. REC'D BY REGISTRAR AN 6		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17154

CERTIFICATE OF DEATH

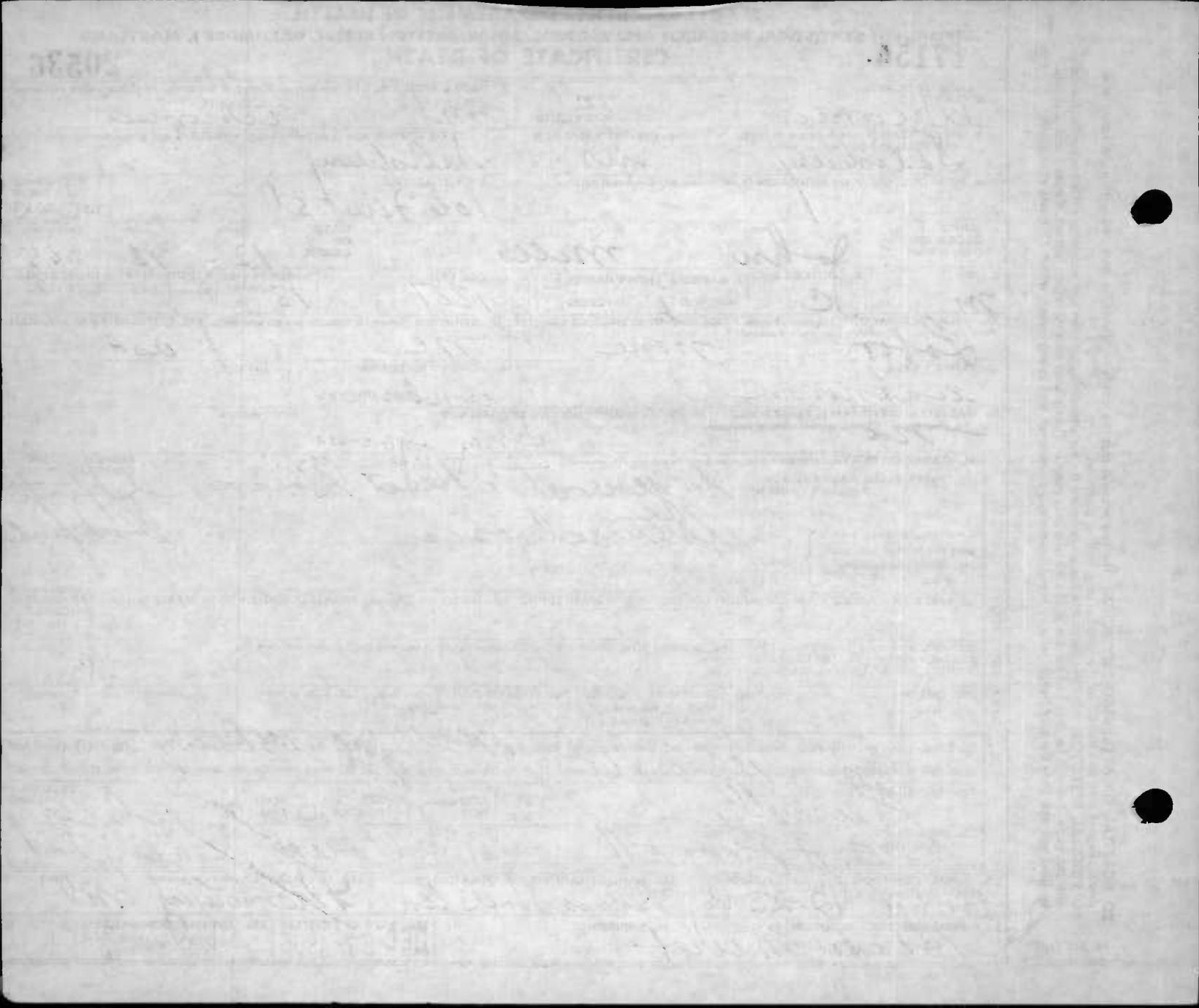
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Wicomico</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <i>106 First St -</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i>miles</i>	Last 4. DATE OF DEATH Month <i>12</i> Day <i>18</i> Year <i>1965</i>
5. SEX <i>m</i>	6. COLOR OR RACE <i>dc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1887</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (County & State, or foreign country) <i>me.</i>
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Dney Young</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4221</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Indefinite</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Degenerative Heart Disease</i>		DUE TO <i>Arteriosclerosis</i>	
(c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 1965</i> to <i>Dec. 18, 1965</i> , that (I) (we) last saw the deceased alive on <i>Nov. 19, 1965</i> , and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>20 Dec 1965</i>	
22e. SIGNATURE <i>E. A. Purcell</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>65 W Main, Salisbury, Md.</i>
22c. PHYSICIAN'S NAME (Type) <i>E. A. Purcell</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
23b. DATE THEREOF <i>12-23-65</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Glass Hill Cem</i>	23d. LOCATION (City, town or county) <i>Gloucester MD</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Brakeen m west</i>		ADDRESS	25a. REC'D BY REGISTRAR DATE <i>DEC 27 1965</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17155 20537

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 407 days		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		d. STREET ADDRESS 120 Denton Road			
3. NAME OF DECEASED (Type or print)	First Clara	Middle	Last	4. DATE OF DEATH Moore	Month December	Day 9	Year 1965		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-22-1881	9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Botton factory worker		10b. KIND OF BUSINESS OR INDUSTRY Botton factory		11. BIRTHPLACE (County & State, or foreign country) Sussex Co. Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN VOSS		14. MOTHER'S MAIDEN NAME LIDA THOMAS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-12-4781		17. INFORMANT Mrs. Elva Witten; Federalsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 days					
332X		DUE TO { Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Recurrent cerebral thrombosis	DUE TO { (c) 	3 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct. 28 , 19 64 , to Dec. 9 , 19 65 , that (I) (we) last saw the deceased alive on Dec. 9 , 19 65 , and that death occurred at M , from the causes and on the date stated above.		22a. SIGNATURE L. V. Maldve		22b. DATE SIGNED 2:15 A.M.					
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22d. ADDRESS Deer's Head State Hospital; Salisbury, Md.		12/9/65		
23a. BURIAL OR CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 9-12-65		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest		23d. LOCATION (City, town or county) (State) Federalsburg, Md.			
24. FUNERAL DIRECTOR Harvey Williamson		ADDRESS Federalsburg, Md.		25a. REC'D BY REGISTRAR DEC 15 1965		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17156

CERTIFICATE OF DEATH

20538

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 5 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt # 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First LINWOOD	Middle WESLEY	Last NUTTER
4. DATE OF DEATH Dec. 15 1965	Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. OATE OF BIRTH 5-21-1914
	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Oriole, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Caleb Nutter		14. MOTHER'S MAIDEN NAME Edith Muir	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW # 2		16. SOCIAL SECURITY NO. 17. INFORMANT 214-10-7101 Betty Nutter, Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct INTERVAL BETWEEN ONSET AND DEATH 4201 5 min			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		OUE TO (b) Coronary artery occlusion 5 min	
		OUE TO (c) coronary arteriosclerosis 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 20 1965 , to Dec 15 1965 , that (I) (we) last saw the deceased alive on Nov 20 1965 , and that death occurred at 10 AM , from the causes and on the date stated above.			
22a. SIGNATURE Dr. L.V. Sohler		22b. DATE SIGNED 12-16-65	
22c. PHYSICIAN'S NAME (Type)		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Delmar, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-17-65	23c. NAME OF CEMETERY OR CREMATORIAL Mardela Memorial
24. FUNERAL DIRECTOR Charles W. Manel - Delmar, Del.		ADDRESS	25a. REC'D BY REGISTRAR DEC 20 1965
			25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Then please attach permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

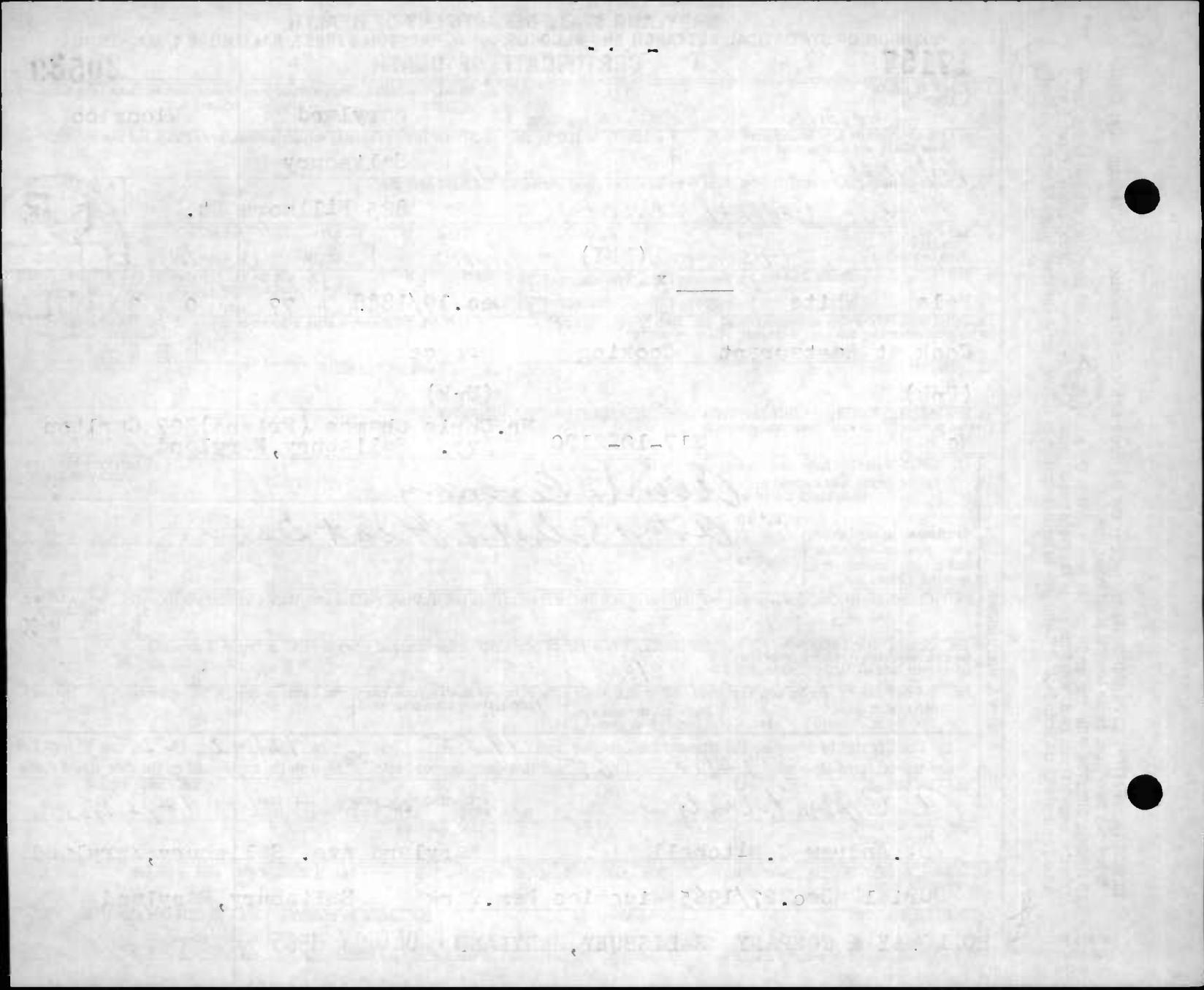
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17157

CERTIFICATE OF DEATH

20539

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Wicomico</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jalisbury</i>		c. LENGTH OF STAY IN 1b <i>12</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Peninsula General Hospital</i>		d. STREET ADDRESS <i>825 Fillmore St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <i>Gus</i>	Middle <i>(NMI)</i>	Last <i>Pappas</i>	4. DATE OF DEATH <i>December 22 1965</i>	Month <i>December</i>	Day <i>22</i>	Year <i>1965</i>				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 19/1888</i>	9. AGE (in years last birthday) <i>77 yrs.</i>	IF UNDER 1 YEAR <i>0</i>	IF UNDER 24 HRS. <i>0</i>	Months <i>0</i>	Days <i>3</i>	Hours <i>0</i>	Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook at Restaurant</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Cooking</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Greece</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>(Unk.)</i>	14. MOTHER'S MAIDEN NAME <i>(Unk.)</i>										
15. WAS DEC EASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>217-10-2170</i>	17. INFORMANT <i>Mr. Chris Chames (Friend)</i>	Address <i>307 Carlton Ave. Salisbury, Maryland</i>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Acute Coronary</i> DUE TO (c) <i>Arterio Sclerotic Heart Disease</i>											INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>N/A</i>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1955</i> , 19, to <i>12/23 1965</i> , that (I) (we) last saw the deceased alive on <i>12/10 1965</i> , and that death occurred at <i>12/23 1965</i> M, from the causes and on the date stated above.		22a. SIGNATURE <i>A.C. Mitchell</i>		22b. DATE SIGNED <i>12/23/65</i>							
22c. PHYSICIAN'S NAME (Type) <i>Dr. Andrew C. Mitchell</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 27/1965</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Wicomico Mem. Park</i>	23d. LOCATION (City, town or county) <i>Salisbury, Maryland</i>		(State)					
24. FUNERAL DIRECTOR <i>HOLLOWAY & COMPANY</i>		ADDRESS <i>SALISBURY, MARYLAND</i>		25a. REC'D BY REGISTRAR <i>DEC 28 1965</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17158 20540

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 300 Washington St				d. STREET ADDRESS 300 Washington St							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) RUSSELL EDWARD PARKER		First	Middle	Last	4. DATE OF DEATH DECEMBER 9 1965	Month	Day	Year			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28/1909		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR 5 Months	IF UNDER 24 HRS. 11 Days	Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furniture Salesman			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Salisbury, Maryland			12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Albert Parker (Deceased)			14. MOTHER'S MAIDEN NAME Minnie Riggan								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. W.W.#2		17. INFORMANT Mrs. Naomi E. Parker (Wife)		Address 300 Washington Street Salisbury, Maryland				INTERVAL BETWEEN ONSET AND DEATH sudden	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction		4201 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. Coronary Artery Disease		DUE TO (b) DUE TO (c)		5-6 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) N/A									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Camden Avenue		(County) Salisbury, Md.		(State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 17/8 1965 , and that death occurred at App.		1960 to 12/9 1965 , that (I) (we) last M, from the causes and on the date stated above.								22b. DATE SIGNED Dec. 1965	
22a. SIGNATURE William D. Gray		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) Dr. William D. Gray		22d. ADDRESS Camden Avenue									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 11/1965		23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park		23d. LOCATION (City, town or county) Salisbury, Maryland		(State)			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DEC 13 1965		25b. REGISTRAR'S SIGNATURE Charles Judge					

MARYLAND STATE DEPARTMENT OF HEALTH

17159

CERTIFICATE OF DEATH

20541

certificate be executed within 24 hours after death.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the hospital or attending physician retain a copy of the report.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and/or any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WICOMICO		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b Princess Anne 19x-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PENINSULA GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY	First JANE	Middle POPE	Last 4. DATE OF DEATH DECEMBER 1 1965
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH Feb 15 1890	9. AGE (in years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Princess Anne Md.	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dame		10b. KIND OF BUSINESS OR INDUSTRY Princess Anne Md. In SA.	
13. FATHER'S NAME Edward Mills		14. MOTHER'S MAIDEN NAME Mary Briddell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Ms Eddie Mulchay Princess Anne May	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction		Address Princess Anne Md.	
260X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Diabetic 170/117.5		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bilateral A.H. Angina Pectoris			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at 94 M , from the causes and on the date stated above.			
22a. SIGNATURE Lester Saylor		22b. DATE SIGNED 22nd	
22c. PHYSICIAN'S NAME (Type) Charles J. Wilson	M.O. ATTENDING PHYS. <input type="checkbox"/> 22d. ADDRESS St. Andrew	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/4/65	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Andrew	23d. LOCATION (City, town or county) Princess Anne Md.
24. FUNERAL DIRECTOR Lewis R. Wilson	ADDRESS Princess Anne Md.	25a. REC'D BY REGISTRAR DEC 7 1965	25b. REGISTRAR'S SIGNATURE Charles J. Wilson

W. H. Clegg
17th Nov.

W. H. Clegg

W. H. Clegg

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>WICOMICO</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		d. STREET ADDRESS <i>1207 TRUITT</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Peninsula General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>George</i>	Middle <i>Thomas</i>	Last <i>Poulson</i>	4. DATE OF DEATH <i>December 19 1965</i>	Month <i>December</i>	Day <i>19</i>	Year <i>1965</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-15-1887</i>	9. AGE (In years last birthday) <i>78 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Rail Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>		11. BIRTHPLACE (County & State, or foreign country) <i>VIRGINIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>ERASMOUS POULSON</i>		14. MOTHER'S MAIDEN NAME <i>ELLEN EAST</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>716-03-1686</i>		17. INFORMANT <i>Ella Poulson-Salisbury, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarct</i>		DUE TO <i>4201</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO <i> </i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of item 18.) <i> </i>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i> </i>	
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <i>12-12 1965</i> to <i>12-19 1965</i> , that (I) (we) last saw the deceased alive on <i>12-9 1965</i> , and that death occurred at <i>at home</i> M, from the causes and on the date stated above.									
22a. SIGNATURE <i>William Q. Collier Jr.</i>		22b. DATE SIGNED <i>12-19-65</i>							
22c. PHYSICIAN'S NAME (Type) <i>Charles W. Marvel - Delmar, Del.</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <i> </i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>12-22-65</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>ST. STEPHENS</i>		23d. LOCATION (City, town or county) <i>DELMAR - DEL</i>		(State)	
24. FUNERAL DIRECTOR <i>Charles W. Marvel - Delmar, Del.</i>		ADDRESS <i> </i>		25a. REC'D BY REGISTRAR <i>DEC 22 1965</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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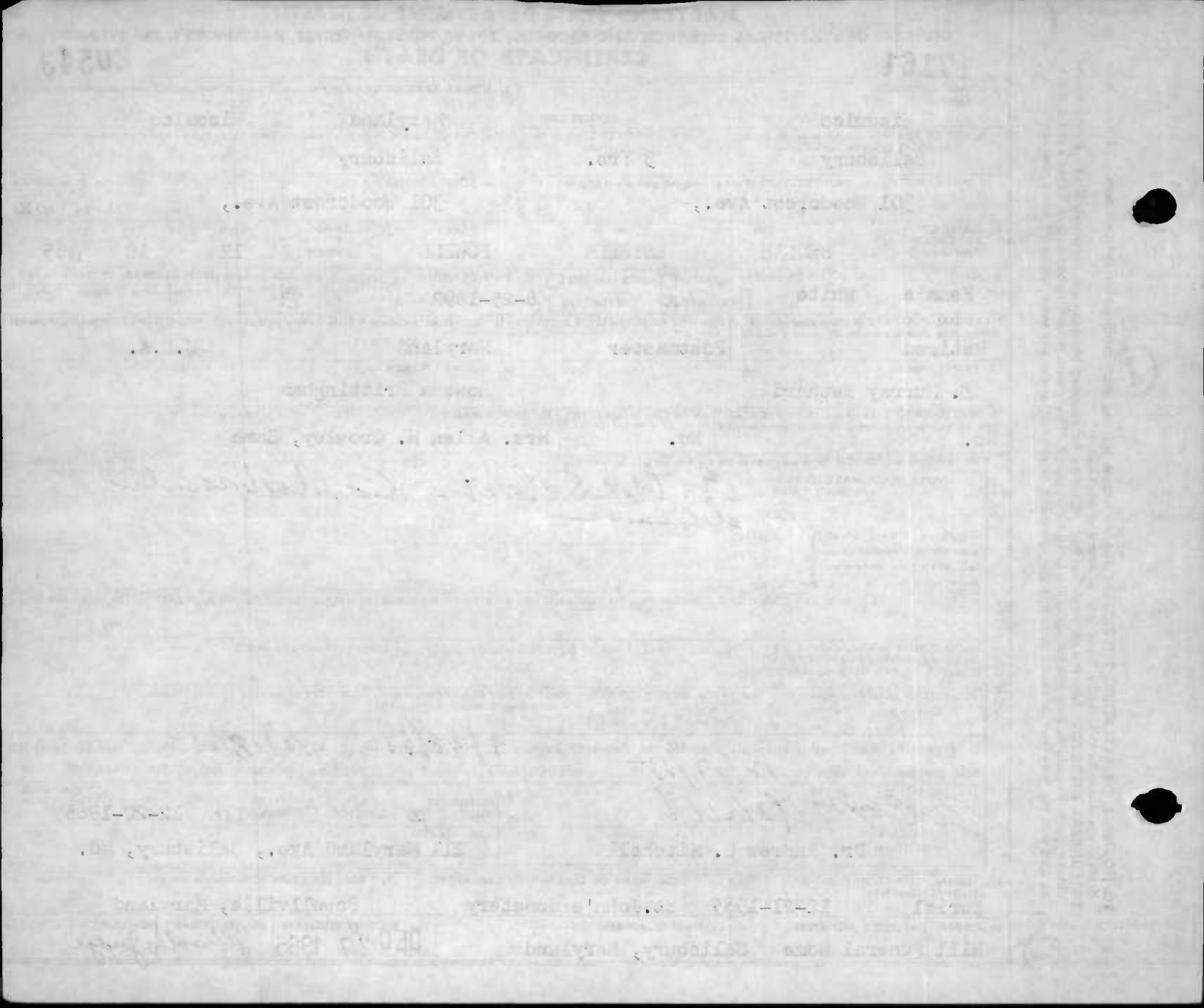
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17161

CERTIFICATE OF DEATH

20543

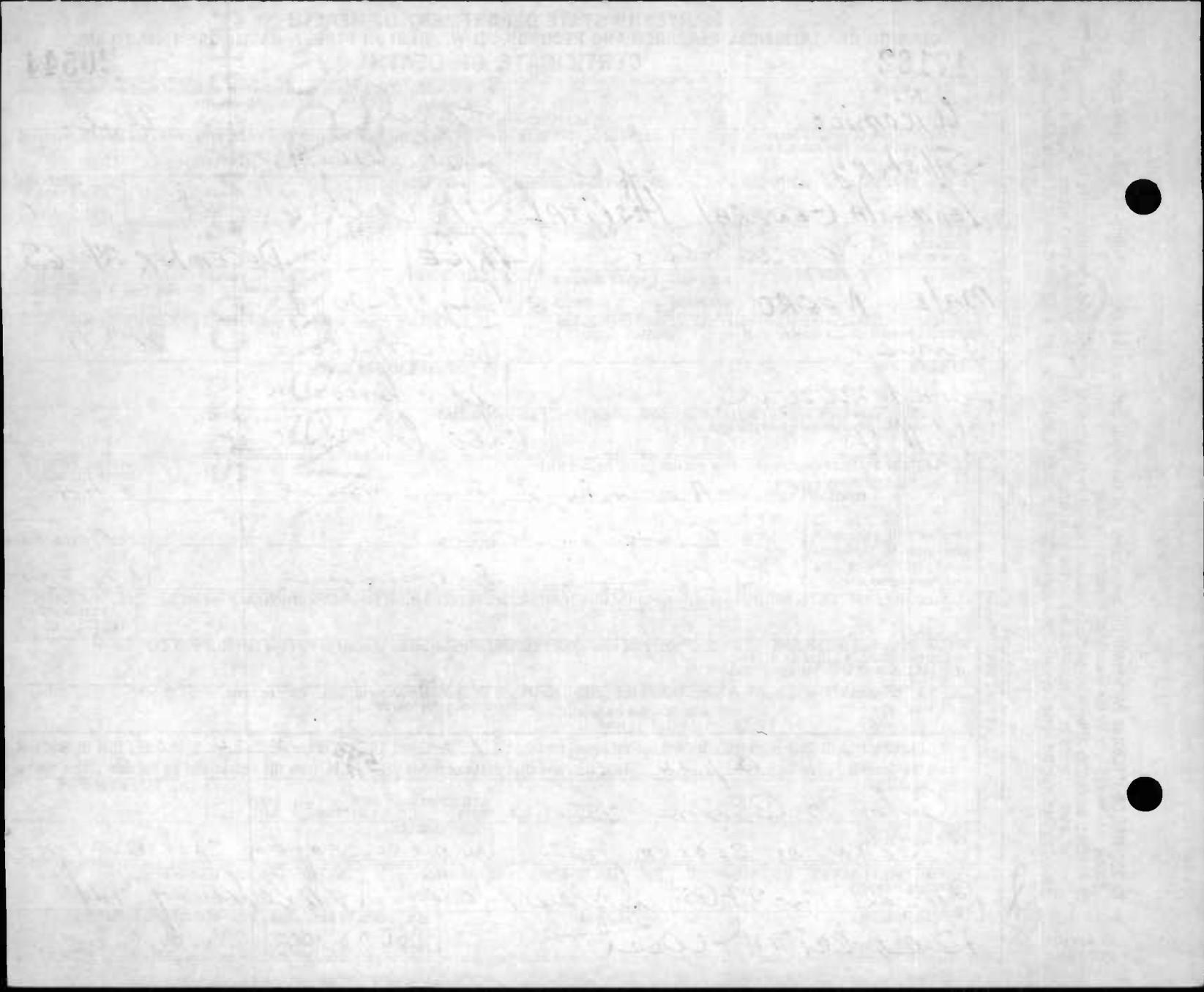
1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b 3 Yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 301 Woodcrest Ave.,		d. STREET ADDRESS 301 Woodcrest Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First BEULAH	Middle ESTELLE	Last POWELL
4. DATE OF DEATH	Month 12	Day 18	Year 1965
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-25-1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Postmaster	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME E. Murray Bethard	14. MOTHER'S MAIDEN NAME Rowena Brittingham		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.	16. SOCIAL SECURITY NO. No.	17. INFORMANT Mrs. Allen H. Crowley, Same	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) 4221		<i>arterio Sclerotic Cardio Vascula</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)		<i>disease -</i>	
} DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) 912863	(County) 19	(State) to 12/18/65	
21. I certify that (I) (this hospital) attended the deceased from 9/28/63 19....., to 12/18/65 , 19....., that (I) (we) last saw the deceased alive on 12/17/65 19....., and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Andrew C. Mitchell</i>		22b. DATE SIGNED 12-20-1965	
22c. PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS 211 Maryland Ave., Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-21-1965	23c. NAME OF CEMETERY OR CREMATORIUM St. John's Cemetery	23d. LOCATION (City, town or county) (State) Powellville, Maryland
24 FUNERAL DIRECTOR'S SIGNATURE Hill Funeral Home		ADDRESS Salisbury, Maryland	25a. REC'D BY REGISTRAR DATE DEC 27 1965
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
17162				20544								
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>			b. COUNTY <i>Wic.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>			c. LENGTH OF STAY IN 1b <i>life</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury MD</i>			d. STREET ADDRESS <i>115 Catherine St</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>PENNSYLVANIA GENERAL Hospital</i>									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>James C. Price</i>			First	Middle	Last	4. DATE OF DEATH <i>DECEMBER 24 1965</i>			Month	Day	Year	
5. SEX <i>Male</i>			6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Aug 19-70</i>	9. AGE (In years last birthday) <i>45 yrs.</i>			10. IF UNDER 1 YEAR Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <i>Wicomico -</i>			12. CITIZEN OF WHAT COUNTRY <i>USA</i>			
13. FATHER'S NAME <i>unknown</i>			14. MOTHER'S MAIDEN NAME <i>unknown</i>			15. WAS DEC EASSED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>17. INFORMANT Cleo Orlston</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhage from Bowel</i>			DUE TO (b) <i>Carcinomatous</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 hr</i>						
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>157X</i>			DUE TO (c) <i>Carcinoma of Bowel</i>			4 Months						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>While at work</i>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>-</i>			20f. (City or town) <i>-</i>	(County) <i>-</i>	(State) <i>-</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>9/12</i> , 19 <i>65</i> , to <i>12/24</i> , 19 <i>65</i> , that (II) (we) last saw the deceased alive on <i>12/24</i> 19 <i>65</i> , and that death occurred at <i>5A.M.</i> from the causes and on the date stated above.									22b. DATE SIGNED			
22a. SIGNATURE <i>John M. Bloxom III</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED						
22c. PHYSICIAN'S NAME (Type) <i>JOHN M. BLOXOM III</i>			22d. ADDRESS <i>MEDICAL CENTER SALISBURY MD</i>									
23a. BURIAL, CREMATION, REMDVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>12-27-65</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Green Acres</i>			23d. LOCATION (City, town or county) <i>Salisbury MD</i>			
24. FUNERAL DIRECTOR <i>Booker McNease</i>			ADDRESS						25a. REC'D BY REGISTRAR <i>REC 28 1965</i>			
									25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

20545

17163		2029-2	
1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTY Talbot	
c. LENGTH OF STAY IN 1b Since 1/16/63		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital		d. STREET ADDRESS 210 Goldsborough Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle Henry	Last Price
4. DATE OF DEATH December 7 1965	Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12/28/1903
9. AGE (In years last birthday) 61 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. BIRTHPLACE (County & State, or foreign country) Talbot Co., Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Price	14. MOTHER'S MAIDEN NAME Zenia Parrott	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. 217-05-9864	17. INFORMANT Records of Pine Bluff State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emphysema			
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Tuberculosis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury
20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 16 1963 to Dec. 7 1965 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 7, 1965 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>E.P. Ritchings</i>			
22b. DATE SIGNED 12/7/65			
22c. PHYSICIAN'S NAME (Type) E. P. Ritchings	22d. ADDRESS Salisbury, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/10/1965	23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Memorial Park	23d. LOCATION (City, town or county) (State) Easton, Md.
24. FUNERAL DIRECTOR MAURICE E. NEUNAM	ADDRESS & SON Easton, Md.	25a. REC'D BY REGISTRAR DEC 10 1965	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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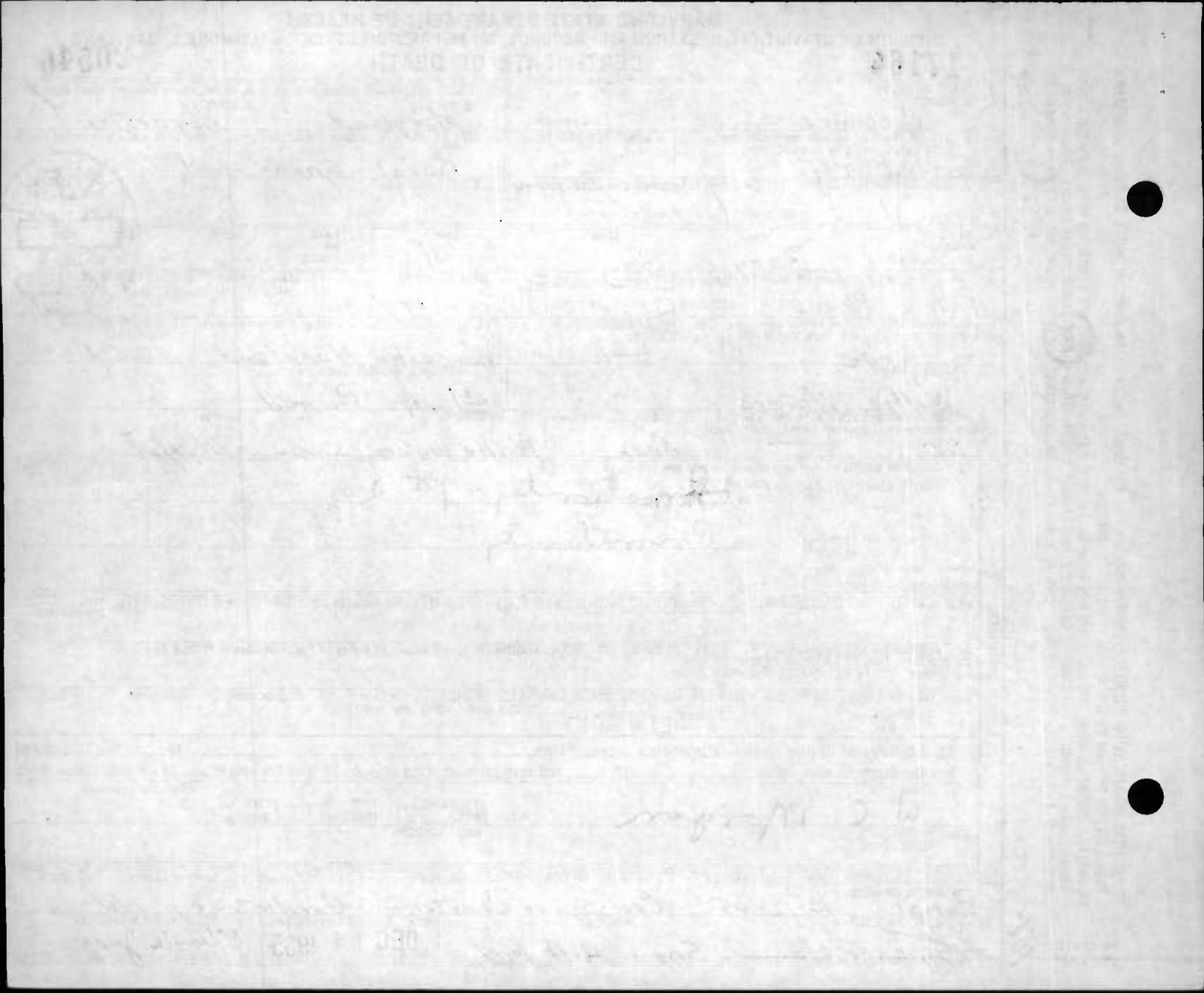
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17164

CERTIFICATE OF DEATH

20546

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Worcester</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, Snow Hill 2382</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Peninsula General Hospital</i>		d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Baby</i>	Middle <i>Boy</i>	Last <i>Purnell</i>	
4. DATE OF DEATH <i>December 10 1965</i>	Month <i>December</i>	Day <i>10</i>	Year <i>1965</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>December 10, 1965</i>	
9. AGE (In years last birthday) <i>5 yrs.</i>	10. IF UNDER 1 YEAR <i>Months</i>	11. IF UNDER 24 HRS. <i>Days</i>	12. IF UNDER 24 HRS. <i>Hours Min.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Worcester Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Willie Waters</i>	14. MOTHER'S MAIDEN NAME <i>Gladys Purnell</i>	Address <i>Willie Waters, Snow Hill, Md.</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Willie Waters, Snow Hill, Md.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hematopathy</i> # 23 DUE TO 776 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pneumopathy</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above.	22a. SIGNATURE <i>W.C. Morgan</i>	22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <i>W.C. Morgan</i>	MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12-12-65</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Coolsprings Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Giddetree Md.</i>	
24. FUNERAL DIRECTOR <i>James F. Flemm, Snow Hill, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>DEC 14 1965</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Wicomico</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>				c. LENGTH OF STAY IN 1b <i>1 yrs</i>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>PENINSULA GENERAL HOSPITAL</i>													
3. NAME OF DECEASED (Type or print) <i>MARGARET</i>				First	Middle	Last	4. DATE OF DEATH <i>ROSE</i>	Month	Day	Year			
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>NEGRO</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-4-08</i>	9. AGE (In years last birthday) <i>62</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Wicomico Co</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>unknown</i>				14. MOTHER'S MAIDEN NAME <i>unknown</i>				Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <i>222-05-3755</i>				17. INFORMANT <i>Anne Childs</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Baltimore</i>		(County) <i>Md</i>	(State) <i>Md</i>		
21. I certify that (I) (this hospital) attended the deceased from <i>12-13</i> , 19 <i>65</i> to <i>12-14</i> , 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>12-14</i> , 19 <i>65</i> , and that death occurred at <i>baltimore</i> M, from the causes and on the date stated above.												22b. DATE SIGNED <i>12-14-65</i>	
22a. SIGNATURE <i>William B. Childs Jr.</i>				M.D.	ATTENDING PHYS.	M.D.	MEO. DIRECTOR	STAFF PHYS.					
22c. PHYSICIAN'S NAME (Type) <i>William B. Childs Jr.</i>				22d. ADDRESS <i>Georgetown</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>12-18-65</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Georgetown Cem</i>		23d. LOCATION (City, town or county) <i>Georgetown</i>				(State) <i>Md</i>	
24. FUNERAL DIRECTOR <i>Booker m West</i>				ADDRESS								25a. REC'D BY REGISTRAR <i>DEC 20 1965</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

REGS

STANFORD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17166

CERTIFICATE OF DEATH

20548

1. PLACE OF DEATH a. COUNTY	Wicomico		MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.	b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Salisbury Maryland		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Willards			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Peninsula General Hospital		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Helen	Middle	Last Shockley	4. DATE OF DEATH	Month December	Day 4	Year 1965
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factual Nurse	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wicomico Co. Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William H. Shockley	14. MOTHER'S MAIDEN NAME Wm'Annie Downs		Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. 214-34-8003	17. INFORMANT					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure 204/ Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Chronic Myelogenous Leukemia (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Pine Bluff Road, Salisbury, Md.	(County) Wicomico	(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Nov 28, 1965 to Dec 4, 1965, that (I) (we) last saw the deceased alive on Dec 4, 1965, and that death occurred at 8:30 P.M., from the causes and on the date stated above.							
22a. SIGNATURE Thomas C. Hill Jr.							
22b. DATE SIGNED Dec 4, 1965							
22c. PHYSICIAN'S NAME (Type) THOMAS C. HILL JR.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 7, 1965	23c. NAME OF CEMETERY OR CREMATORIAL Mitchell	23d. LOCATION (City, town or county) (State) Willards Md.			
24. FUNERAL DIRECTOR ADDRESS Henry W. Watson, Pocomoke City, Md.							
25a. REC'D BY REGISTRAR DEC 7 1965				25b. REGISTRAR'S SIGNATURE Charles Judge			

PCO



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20549

17167								
1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) P.G.Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Pearl		First Edna	Middle Smack					
4. DATE OF DEATH Dec. 6th, 1965	Month	Day	Year					
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5.1912					
9. AGE (In years last birthday) 53 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Somerset, Co. Md.					
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Edward Washburn	14. MOTHER'S MAIDEN NAME Maybelle Hitch	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No or unknown) No	16. SOCIAL SECURITY NO. 212-16-7234	17. INFORMANT Mr. Peter Linwood Smack (Husband) P.O. Box #98 Eden, Maryland	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Tumor of Brain</i> 237X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
ACTUAL SIGNATURE <i>DR. Earl L. Royer</i>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED 12-7-65
23a. BURIAL, CREMATION, BURIAL (Specify)		23b. DATE THEREOF Dec. 9.65.	23c. NAME OF CEMETERY OR CREMATORIAL St. Johns Cemetery,	23d. LOCATION (City, town or county) Powellville, Md.			(State)	
24. FUNERAL DIRECTOR Holloway & Co.		ADDRESS Salisbury, Maryland.		25a. REC'D BY REGISTRAR DEC 9	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

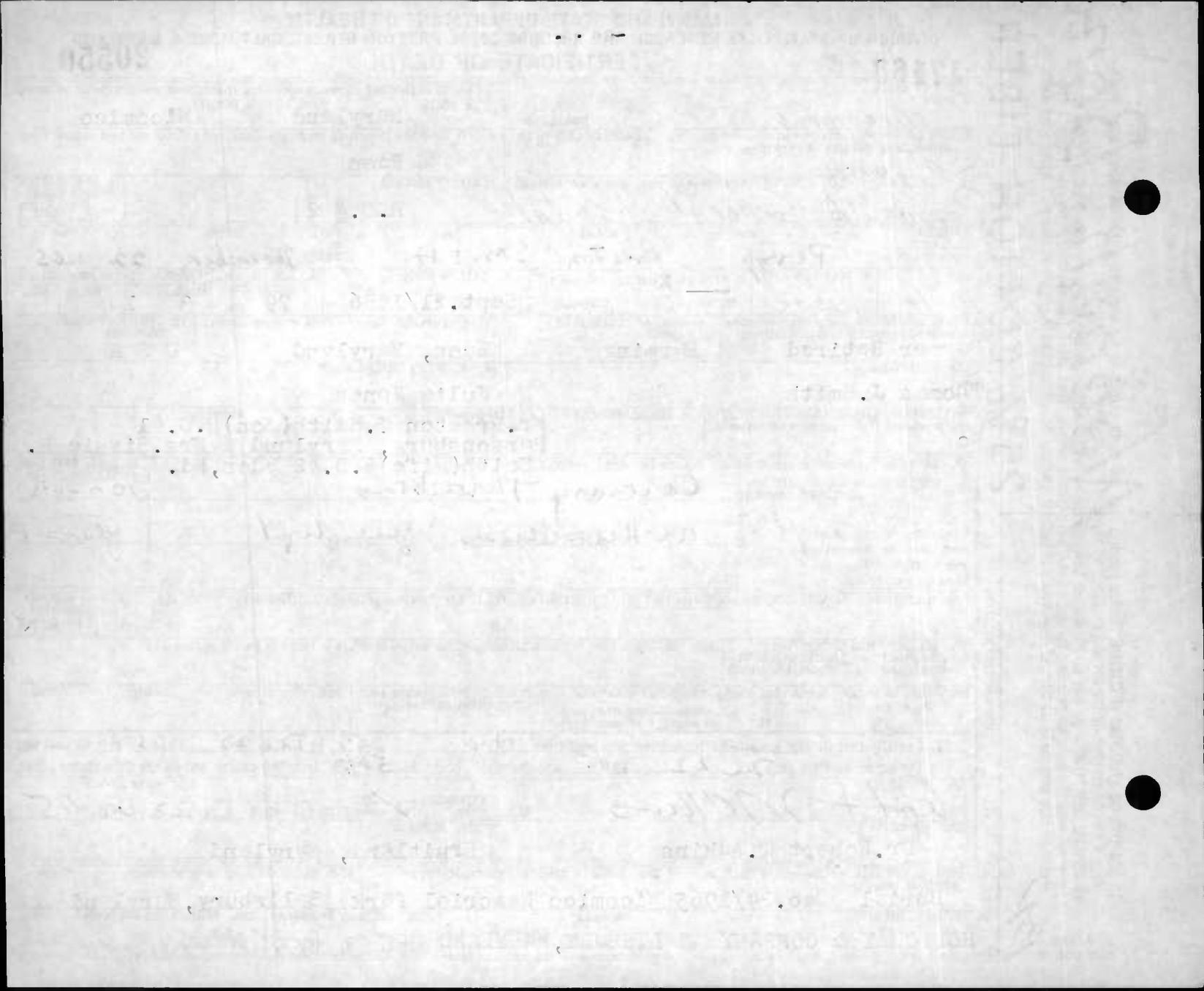
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

20550

17168							
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Wicomico</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) <i>X Eden</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Peninsula General Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Perry</i>		First <i>Perry</i>	Middle <i>Preston</i>				
4. DATE OF DEATH <i>December 22 1965</i>	Last <i>S.M.T.H</i>	Month <i>December</i>	Day <i>22</i>	Year <i>1965</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 21/1886</i>	9. AGE (In years last birthday) <i>79 yrs.</i>	10. IF UNDER 1 YEAR <i>3 months</i>	11. IF UNDER 24 HRS. <i>3 days</i>	12. Hours <i>1 Min.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Eden, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Thomas J. Smith</i>		14. MOTHER'S MAIDEN NAME <i>Julia Jones</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Preston T. Smith (Son) R.D.#1</i>		Address <i>Parsonsburg, Maryland & Mrs. Sissie P.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i>		DUE TO (b) <i>atherosclerosis, generalized</i>		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 minutes</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Fruitland, Maryland</i>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug. 1959</i> , to <i>Dec 22, 1965</i> , that (I) was last saw the deceased alive on <i>Dec 22 1965</i> , and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>R. T. Adkins</i>		22b. DATE SIGNED <i>22 Dec 65</i>					
22c. PHYSICIAN'S NAME (Type) <i>Dr. Robert T. Adkins</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 24/1965</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Wicomico Memorial Park</i>		23d. LOCATION (City, town or county) (State) <i>Salisbury, Maryland</i>	
24. FUNERAL DIRECTOR <i>HOLLOWAY & COMPANY</i>		ADDRESS <i>SALISBURY, MARYLAND</i>		25a. REC'D BY REGISTRAR <i>DEC 28 1965</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17169 CERTIFICATE OF DEATH 2055

CERTIFICATE OF DEATH

20551

The death certificate was executed within 24 hours after death.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1, apd 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death Page 4 may be retained by the hospital or attending physician.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)					
Wisconsin		a. STATE Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		b. COUNTY Worcester					
Saxisbury		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Snow Hill 23X-2					
Peninsula General		d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print)		First	Middle				
Holland			Last				
4. DATE OF DEATH		Month	Day				
Stanford		December	3				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS
Male		White		June 3 1913	52 yrs.	Months Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Owner		Amusement Machines		Snow Hill Md.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address			
Wm David Stanford		Mary E. Payne					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH	
No		215-20-0479		Elva S. Dryden, Snow Hill, Maryland		3 days	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201							
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							
Cerebral Myocardial infarct 3 days Cirteriosclerotic Heart Disease Yes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that (I) (this hospital) attended the deceased from Nov 29, 1965, to Dec 3, 1965, that (I) (we) last saw the deceased alive on Dec 3, 1965, and that death occurred at 11 AM, from the causes and on the date stated above							
22a. SIGNATURE DAVID RAPAT 110 M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type)		DAVID RAPAT		22d. ADDRESS		Snow Hill Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county) (State)	
Burial		12-6-65		Whitestreet Methodist		Snow Hill, Maryland	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Sommer F. Dennis, Snow Hill, Md.				DEC 7 1965		Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												20552	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)									
a. COUNTY Wicomico				a. STATE MARYLAND									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1B 2 weeks									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS Route # 1									
3. NAME OF DECEASED (Type or print) Groveman				First	Middle	Last	4. DATE OF DEATH 12-1-65	Month	Day	Year			
5. SEX M				6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4-15-86	9. AGE (in years last birthday) 79 yrs.	IF UNDER 1 YEAR Months	Days	Hours	IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman				10b. KIND OF BUSINESS OR INDUSTRY Seafood				11. BIRTHPLACE (State or foreign country) Crisfield, Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Noah T. Sterling				14. MOTHER'S MAIDEN NAME Mary Elizabeth Tyler									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) None				16. SOCIAL SECURITY NO. 218-16-5008				17. INFORMANT Percy G. Sterling, Salisbury, Maryland				Address 901 E. Church St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4222 Congestive Heart Failure				INTERVAL BETWEEN ONSET AND DEATH hours									
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. 4222 Hypertension				DUE TO (b) years	DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												22. DATE SIGNED 12-6-65	
ACTUAL SIGNATURE Earl L. Royer, M.D.													
EXAMINER'S NAME (Type) Earl L. Royer, M.D.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/7/65				23c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery				23d. LOCATION (City, town or county) Crisfield, Maryland	
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Maryland													
ADDRESS				25a. REC'D BY REGISTRAR DEC 10 1965				25b. REGISTRAR'S SIGNATURE Charles Judge					
VR AISM (5) 5M 1/65													

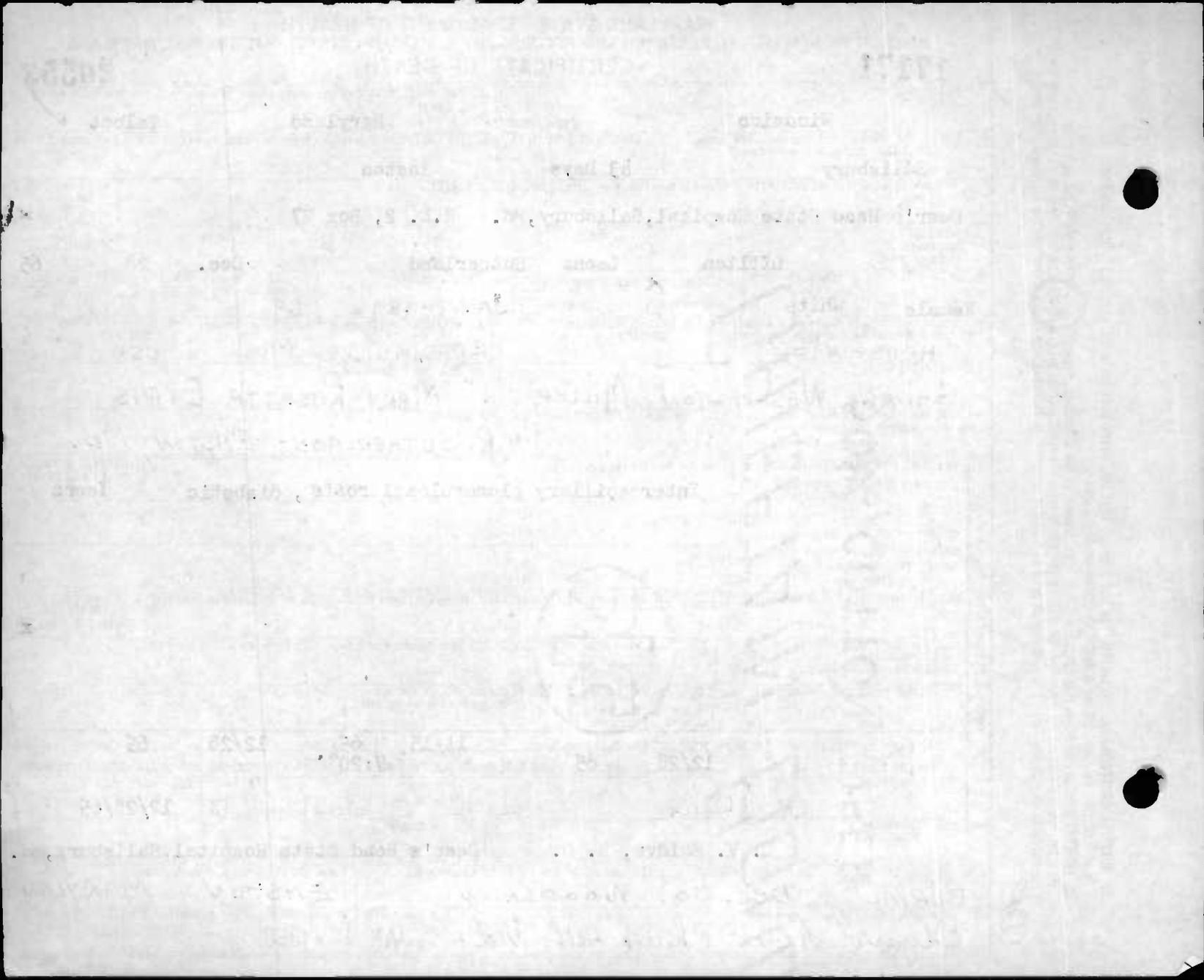
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John

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
17171				20553											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 43 Days											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Lillian				First	Middle	Last	4. DATE OF DEATH Dec. 28 1965	Month	Day	Year					
5. SEX Female				6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH JAN. 1 - 1896	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) GRASONVILLE MD.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Washington Miller				14. MOTHER'S MAIDEN NAME MARY Rosetta Evans											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address W.R. SUTHERLAND - EASTON, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intercapillary glomerulosclerosis, diabetic INTERVAL BETWEEN ONSET AND DEATH 260X Years DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 12/28 1965, to 12/28 1965, that (I) (we) last saw the deceased alive on 12/28 1965, and that death occurred at 7:20 M, from the causes and on the date stated above.															
22a. SIGNATURE <i>W. V. Maldve,</i>				22b. DATE SIGNED 12/28/65											
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.				22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.											
23a. BURIAL, CREMATION, REMDVAL (Society) BURIAL				23b. DATE THEREOF Dec. 30				23c. NAME OF CEMETERY OR CREMATORIUM WOODLAWN				23d. LOCATION (City, town or county) (State) EASTON MARYLAND			
24. FUNERAL DIRECTOR Edgar L. Haneel Church Hill, Md.				25a. REC'D BY REGISTRAR DATE JAN 4 1966								25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
ADDRESS															



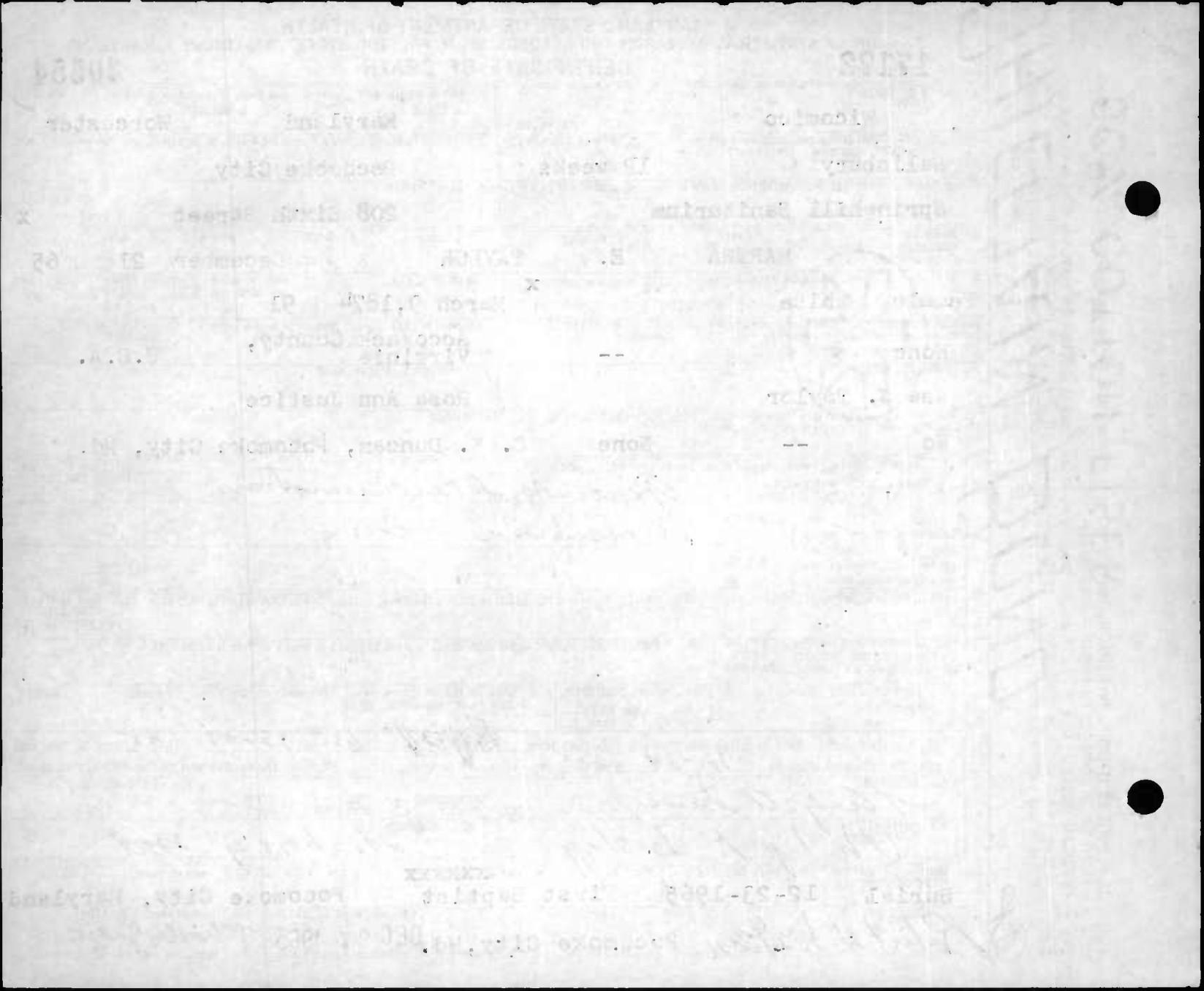
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17172 20554

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12 weeks		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springhill Sanitarium				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		d. STREET ADDRESS 208 Sixth Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARTHA		First	Middle	Last	4. DATE OF DEATH December 21 1965		Month	Day	Year		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1874		9. AGE (in years last birthday) 91 yrs.	10. IF UNDERTAKER 1 YEAR MONTHS DAYS HOURS MIN.	11. BIRTHPLACE (County & State, or foreign country) Accomack County, Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --		11. MOTHER'S MAIDEN NAME Rosa Ann Justice		14. INFORMANT C. K. Duncan, Pocomoke City, Md.		Address			
13. FATHER'S NAME Asa J. Taylor		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT C. K. Duncan, Pocomoke City, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1538		OUE TO (b)	<i>Generalized Carcinomatosis</i>				INTERVAL BETWEEN ONSET AND DEATH				
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. Caecum & Colon		OUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Pocomoke City		(County) Worcester	(State) Maryland		
21. I certify that (I) (this hospital) attended the deceased from Sept 28, 1965 , to 12-21, 1965 , that (I) (we) last saw the deceased alive on 12-14 1965 , and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE <i>Julia Insley</i>		22b. DATE SIGNED Dec 27, 1965									
22c. PHYSICIAN'S NAME (Type) Ch. J. Insley		22d. ADDRESS Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-23-1965		23c. NAME OF CEMETERY First Baptist		23d. LOCATION (City, town or county) Pocomoke City, Maryland		(State)			
24. FUNERAL DIRECTOR Robert H. Watson		25a. REC'D BY REGISTRAR Pocomoke City, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE DEC 27 1965					
VR A15 (4) 20M 1/65											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17173

CERTIFICATE OF DEATH

20555

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
Wicomico MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	MARYLAND Wicomico	
Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Peninsula General Hospital		Ocean City 23x2	

82

3. NAME OF DECEASED (Type or print)	First Violet	Middle W.	Last Taylor	4. DATE OF DEATH December 19 1965
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5. SEX Female	6. COLOR OR RACE WV	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1904	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary	10b. KIND OF BUSINESS OR INDUSTRY Farm House Atom	11. BIRTHPLACE (County & State, or foreign country) EASTON MD	12. CITIZEN OF WHAT COUNTRY? US
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13. FATHER'S NAME WINFIELD S. WALLACE	14. MOTHER'S MAIDEN NAME EVELYN BAKER
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT SCOTT WALLACE, OCEAN CITY MD	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X	Metastases to Spine and Intestinal Tract
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.	DUE TO (b) Carcinoma of Uterus
	DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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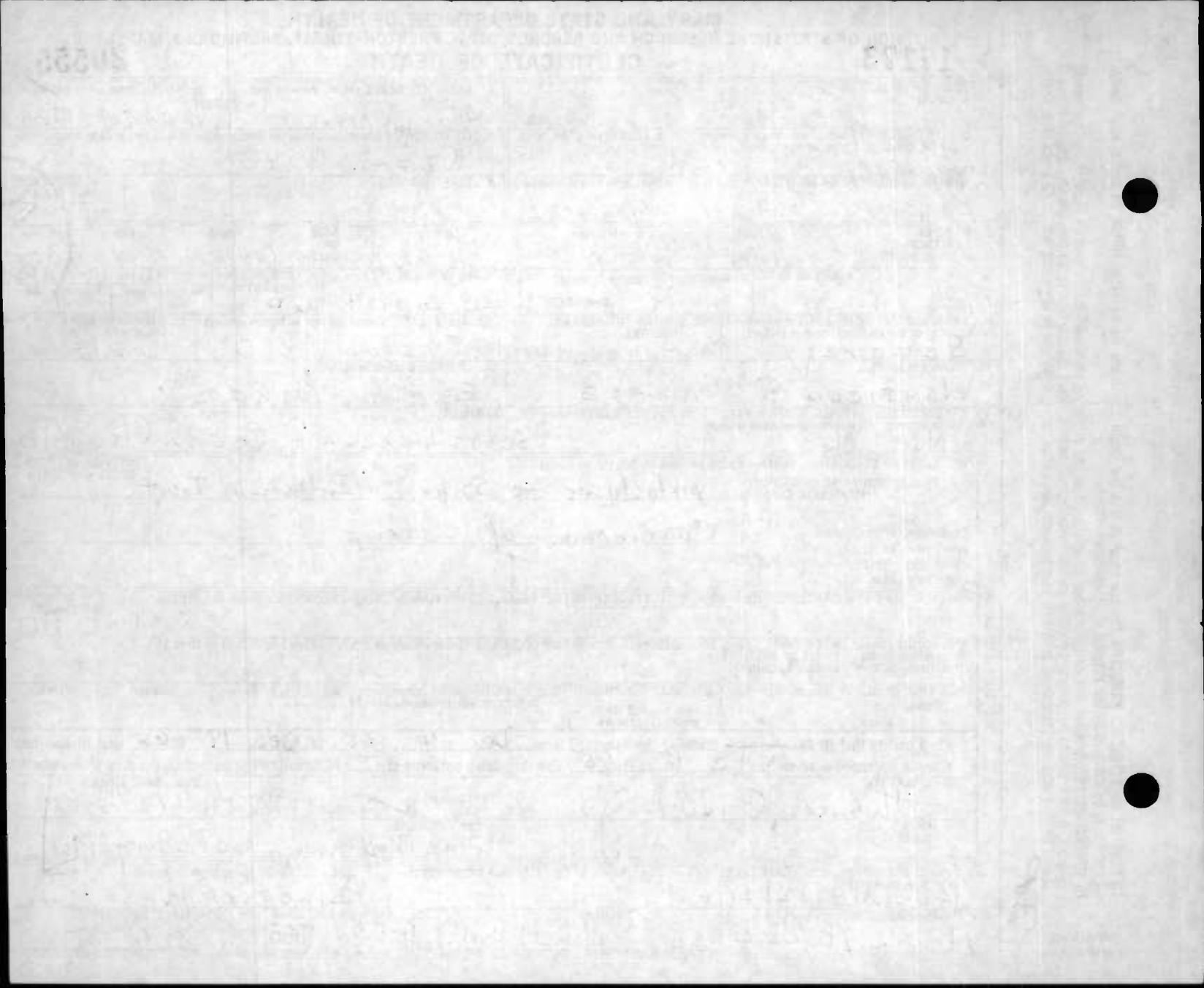
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			

21. I certify that (I) <input type="checkbox"/> attended the deceased from Dec 4, 1965, to Dec 19, 1965, that (I) <input type="checkbox"/> last saw the deceased alive on Dec 18, 1965, and that death occurred at 537 M, from the causes and on the date stated above.	22b. DATE SIGNED 12/19/65
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22a. SIGNATURE Thomas C Hill Jr.	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS Pine Bluff Road, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/21/65	23c. NAME OF CEMETERY OR CREMATORIAL PRINCESS ANN MD	23d. LOCATION (City, town or county) (State)
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24. FUNERAL DIRECTOR Anne A. Burdage	ADDRESS Berlin Md.	25a. REC'D BY REGISTRAR DEC 27 1965	25b. REGISTRAR'S SIGNATURE Charles Judge
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17174

211556

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stockton, md.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsula General Hospital</i>		d. STREET ADDRESS <i>Box 125</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Russell Edward Townsend</i>		First	Middle
4. DATE OF DEATH <i>December 6 1965</i>		Last	Month Day Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 12, 1902</i>
9. AGE (In years last birthday) <i>62 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min. <i>0 0 0 0</i>	11. IF UNDER 24 HRS. Months Days Hours Min. <i>0 0 0 0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>factory</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Townsend</i>		14. MOTHER'S MAIDEN NAME <i>Nora Rowley</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>222-07-7019</i>	
17. INFORMANT <i>Elaine Hudson</i>		Address <i>Gordletree, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>591X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks</i>	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.</i>		years	
DUE TO (b) <i>Neoplastic Syndrome</i>		years	
DUE TO (c) <i>Hypertension</i>		years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>
20f. (City or town) <i>Stockton</i>		(County) (State) <i>Stockton, Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>OCT 10, 1965</i> to <i>DEC 6, 1965</i> , that (II) (we) last saw the deceased alive on <i>Oct 6 1965</i> , and that death occurred at <i>97 M</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>David Raft MD.</i>		22b. DATE SIGNED <i>12-9-65</i>	
22c. PHYSICIAN'S NAME (Type) <i>DAVID RAFT</i>		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>S. 102 1/2 Hwy Rd.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-12-65</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Home Beneficial</i>		23d. LOCATION (City, town or county) (State) <i>Stockton, Md.</i>	
24. FUNERAL DIRECTOR <i>Edgar Wharton - New Church, Va.</i>		ADDRESS	
25a. REC'D BY REGISTRAR <i>DEC 15 1965</i>		25b. REGISTRAR'S SIGNATURE <i>Gloucester Judge</i>	

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1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY WICOMICO				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				c. LENGTH OF STAY IN 1b 17 yrs								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)												
3. NAME OF DECEASED (Type or print) LILLIE J. TYRE				First	Middle	Last	4. DATE OF DEATH Month DEC 29 1965	Day	Year			
5. SEX F		6. COLOR OF RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 15, 1886		9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 7	11. IF UNDER 24 HRS. Days 9	12. IF UNDER 24 HRS. Hours 5	13. CITIZEN OF WHAT COUNTRY? U.S.A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY SELF EMP				11. BIRTHPLACE (County & State, or foreign country) NEWARK MD				12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ISAAC H. JONES				14. MOTHER'S MAIDEN NAME ELIZA ESHAM.								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 219-14-3211 A				17. INFORMANT Mrs. BROWNIE POWELL, SALISBURY MD				Address 510 PRICILLA ST
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332 X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO Generalized Arteritis sclerosis yse.												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1963 , 19, to death , 19, that (I) (we) last saw the deceased alive on Dec 22 1963 , and that death occurred at 97 M, from the causes and on the date stated above.				22b. DATE SIGNED								
22a. SIGNATURE Linda Lawrence, M.D.				22b. DATE SIGNED								
22c. PHYSICIAN'S NAME (Type)				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS Salisbury Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/31/65		23c. NAME OF CEMETERY OR CREMATORIUM EVERGREEN		23d. LOCATION (City, town or county) BERLIN		(State) M.D.				
24. FUNERAL DIRECTOR Anna A. Burbage				ADDRESS Berlin Md.		25a. REC'D BY REGISTRAR JAN 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17176

1. PLACE OF DEATH
a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Tyraskin

c. LENGTH OF STAY IN 1b

Lifetime

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

M

Negro

WIDOWED DIVORCED

10-28-65

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Kenneth E. Waters

14. MOTHER'S MAIDEN NAME

Bertha Dickerson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, enter year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

INTERVAL BETWEEN
ONSET AND DEATH
days

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Interstitial pneumonia

525X
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.
(b)
(c)

DUE TO

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. 20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)
Earl L. Royer, M.D.23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE

CHARLES JUDGE

✓

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17177

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20559

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) e. STATE Georgia b. COUNTY Appling	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Salisbury		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baxley Rural 49X3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Naylor Road		d. STREET ADDRESS Route 3	
3. NAME OF DECEASED (Type or print) First Henry Middle Allex Last Wells		4. DATE OF DEATH Month Dec. Day Year Dec. 18 1965	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Nov. 13, 1930 9. AGE (in years last birthday) 35 yrs. IF UNDER 1 YEAR Months Days Hours Min.			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinest		10b. KIND OF BUSINESS OR INDUSTRY Machinery	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Sarah Wells	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Aline M. Wells		Address Route 3 Baxley, Georgia	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Fracture of Skull INTERVAL BETWEEN ONSET AND DEATH 8104	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO	
{		DUE TO	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto struck by + run - (Driver of Auto)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 10.25 a.m. 12 18 65		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Naylor Rd 20f. (City or town) Salisbury (County) Wicomico (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl Roger		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Roger MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE SIGNED 12-19-65	
22b. DATE THEREOF 12/23/1965		22c. NAME OF CEMETERY OR CREMATORIAL Satilla Cemetery	
22d. LOCATION (City, town, or county) Jeff Davis County, Ga.		(State)	
23. FUNERAL DIRECTOR Thomas Wallace Salisbury, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DEC 21 1965		24b. REGISTRAR'S SIGNATURE Charles Judge	
DATE			

Mar 2 p. entered

1002

(Taqwa) went to church
by new (pedal) 2291-51 0.10

22-51
Signed AM 10-10-1957

2
1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17178

205611

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>Wicomico</i>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1D		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X SALISBURY</i>										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Peninsula General Hospital</i>		d. STREET ADDRESS <i>RT # 2</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
3. NAME OF DECEASED (Type or print)	First <i>Lola</i>	Middle <i>Mae</i>	Last <i>Whaley</i>	4. DATE OF DEATH <i>December 2 1965</i>	Month Day Year	5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-31-1905</i>	9. AGE (In years last birthday) <i>60 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	11. KIND OF BUSINESS OR INDUSTRY <i>DR</i>	12. BIRTHPLACE (County & State, or foreign country) <i>DEL</i>	13. CITIZEN OF WHAT COUNTRY? <i>USA</i>
14. FATHER'S NAME <i>JAMES WOOTTEN</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>222-07-2834</i>	17. INFORMANT <i>Earl Whaley - SALISBURY</i>	Address <i>MD.</i>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i>		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH <i>One month</i>										
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>"</i>		DUE TO (b) <i>"</i>	DUE TO (c) <i>Arteriosclerosis</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>St. STEPHENS</i>		20f. (City or town) (County) (State) <i>Delmar - DEL</i>								
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 11 1965</i> to <i>Dec 2 1965</i> , that (I) (we) last saw the deceased alive on <i>Dec 2 1965</i> , and that death occurred at <i>222</i> M, from the causes and on the date stated above.						22b. DATE SIGNED <i>Charles J. Charles</i>								
22a. SIGNATURE <i>Charles J. Charles</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>Charles J. Charles</i>									
22c. PHYSICIAN'S NAME (Type) <i>Charles J. Charles</i>														

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>12-6-65</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>ST. STEPHENS</i>	23d. LOCATION (City, town or county) (State) <i>DELMAR - DEL</i>
24. FUNERAL DIRECTOR <i>Charles J. Charles</i>	ADDRESS <i>W. Maryland - Delmar Del.</i>	25a. REC'D BY REGISTRAR <i>DEC 6 1965</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Charles</i>

2001 10330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
17179

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

20561

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pen. Gen. Hospital		d. STREET ADDRESS 1 610 Truitt Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle MILBOURNE	Last WILLING
4. DATE OF DEATH DEC. 22nd 1965	Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28/1900
9. AGE (In years last birthday) 65 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. 12. CITIZEN OF WHAT COUNTRY U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radio Repairman		10b. KIND OF BUSINESS OR INDUSTRY Radio	
11. BIRTHPLACE (County & State, or foreign country) Nanticoke, Maryland		12. INFORMANT Mrs. Tressia N. Willing (Wife) Address 610 Truitt Street Salisbury, Maryland	
13. FATHER'S NAME George Willing		14. MOTHER'S MAIDEN NAME Leah Webster	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-30-8485 17. INFORMANT Mrs. Tressia N. Willing (Wife) Address 610 Truitt Street Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Coronary occlusion Coronary arteriosclerosis. INTERVAL BETWEEN ONSET AND DEATH 20 min 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____ saw the deceased alive on _____, and that death occurred at _____ M, from the causes and on the date stated above.		App. 19 ⁵⁵ to Dec 22, 1965, that (I) (we) last saw the deceased alive on Dec 20 1965, and that death occurred at _____ M, from the causes and on the date stated above.	
22a. SIGNATURE Dr. L.V. Sohler		22b. DATE SIGNED Dec. 24/1965	
22c. PHYSICIAN'S NAME (Type) Dr. L.V. Sohler		22d. ADDRESS Delmar, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Dec. 27/1965		23b. DATE THEREOF Parsons Cemetery	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Parsons Cemetery		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR DATE DEC 28 1965	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

ORANGE JUICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17180		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
e. COUNTY Wicomico		a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden (Rural)	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS R.D.# 1	
4. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Norman Lin Wood		First	Middle
Last		4. DATE OF DEATH DECEMBER 27 1965	Month Day Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Aug. 13/1905		9. AGE (In years last birthday) 60 yrs. IF UNDER 1 YEAR Months 4 Days 14 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee - Frozen Food Co.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Wor. County, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Josiah Wilson		14. MOTHER'S MAIDEN NAME Lena T. Shockley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 17 INFORMANT 220-12-0266 Mrs. Eva E. Wilson (Wife) R.D.#1 Eden, Maryland	
Address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		SEC.	
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		YEARS	
DUE TO (b)		Acute coronary Occlusion	
DUE TO (c)		Coronary atherosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		N/A	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 19 to 12-27 1965, that (I) (we) last saw the deceased alive on 19 and that death occurred at 12:30 AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Hubert R. White, Jr.</i>		22b. DATE SIGNED Dec. 27/1965	
22c. PHYSICIAN'S NAME (Type) Dr. Hubert R. White, Jr.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS Fruitland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 30/1965	
23c. NAME OF CEMETERY OR CREMATORIAL Zion Cemetery		23d. LOCATION (City, town or county) (State) Near Fruitland, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND	
25a. REC'D. BY REGISTRAR DEC 28 1965		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

